Can Maternity Services Open Up to the Indigenous Traditions of Midwifery?

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Mainstreaming the ayurveda, yoga, unani, siddha, homeopathy systems should imply deep changes in maternity care. Big changes there are, but in the wrong direction. Aiming to reduce maternal and neonatal mortality, the National Rural Health Mission’s Janani Suraksha Yojana scheme presses expectant mothers to go for “institutional delivery” and avoid home births. The NRHM document also speaks of revitalising local health traditions. This means that the dais who have been part of the local health traditions should be incorporated into the government structure at the lowest end as has always been the case. This paper raises various questions related to maternity care governance for the benefit of local communities and looks at the possibilities of strengthening the services with serious inputs from dais. It acknowledges the dimensions of class, caste, gender, power and ideology that would be implicated in the acceptance of the “dai tradition” within the healthcare services system.

Mainstreaming” the ayurveda, yoga, unani, siddha, homeopathy (AYUSH) non-allopathic systems in national health policy and programmes in the Eleventh Five-Year Plan (2007-12) belatedly acknowledges the plurality of ways of healing in Indian society. Perhaps fittingly the National Rural Health Mission (NRHM) is posited as the prime field in which to operationalise this step, of which maternity care is a prominent part. However, aiming towards reducing maternal and neonatal mortality through the Janani Suraksha Yojana (JSY) scheme, the NRHM strongly urges expectant mothers to go for “institutional delivery” and to avoid home births. Considering that most birthing women in the least-served areas presently still take the help of dais, it is ironic that the government is now marginalising these brave women and their age-old tradition of childbirth care, rudely excluding them from the category of “skilled birth attendants”.

In fact, the “mainstream” context for maternity care is not very clear. Is it supposed to mean “hospital-centred” pregnancy and childbirth care? If so, it is important to realise that there is already a valid critique of that model as invasive, gender-insensitive and commercialised. Do we want to integrate certain woman-friendly non-allopathic practices into existing healthcare structures (hospitals, health centres) to humanise them, making them gender-sensitive and less commercialised? Or would we like to see parallel services for pregnancy and childbirth care based on indigenous healing and midwifery traditions? Do we mean to institutionalise changes only at the primary health centre (PHC) level, basically for the rural poor? Might dais play a prominent role at that level? Might referral units (usually allopathic) somehow become sensitive to the knowledge and skill of dais, so they can back up home births in a model of community-based cooperation and coordination?

With questions like these in mind, we argue for incorporating the best of indigenous midwifery in terms of knowledge, outlook and practices. We aspire for a well-linked system of woman-friendly comprehensive maternity services where medical institutions not only serve as essential referral facilities for obstetric care but also harmonise with and respect the ground of indigenous cultures and practices. A vision like this demands consideration of class, caste, gender, power and ideology dimensions that would be implicated in the acceptance of the “dai tradition” within the healthcare services system.

1 Health Governance, Marginalisation and Openings

The World Health Organisation (WHO), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA) and other global agencies tend to see the high maternal and infant.
mortality in developing countries as an emergency to be met through technological and managerial solutions, with indigenous systems and communities as part of the problem rather than a resource base for solutions. Blaming the traditional birth attendants (TBAs, or “dais” in India) for deaths of mothers and babies dates from colonial times but it has now become louder. After over three decades of official support for TBA training to extend primary healthcare for women, the stand has been reversed. In post-independent India, the Mother and Child Health policy and services of the 1960s and 1970s gave way to the Child Survival and Safe Motherhood programme in the 1980s and in the 1990s to the Reproductive and Child Health (RCH-I) programme. Since April 2005 RCH-II has been subsumed under the NRHM. While primary healthcare was supposed to emphasise safe motherhood and child survival, this always got reduced to vertical programmes of iron and folic acid supplements, immunisation and oral rehydration for diarrhoea, with family planning (population control) cornering a disproportionate share of concern and resources. The NRHM purports to overcome verticalisation by serving as an umbrella for all public health activities in rural areas, focusing broadly on women’s health and welfare.

The trained dais were never effectively linked with the health services, government policy viewing them as community participants or volunteers with no more than limited training and minimal connection with the formal system. Since around 2000, however, global donors have pressured the government to exclude TBA training from the reproductive health activities they fund, specifically from RCH-II. With little by way of alternative and independent initiatives to support it, most states have let dais-training lapse. Exceptions are Gujarat and Andhra Pradesh (CHETNA 2005).

After broad social sector cutbacks in the 1990s, the slowing of decline in infant mortality and other factors prompted reconsideration of the health governance strategy. It reflected in the “well-being” approach of the National Population Policy (2001) and in the call of the National Health Policy (2002) for achieving equity in basic healthcare through decentralised services with plurality of knowledge systems and providers as envisioned for the NRHM. Policy shifts like these hopefully represent genuine intent of the state to address the inequities in the health services and provide openings for change.

2 History of Dai Training

Training of dais in India began during the British era, aiming to reduce maternal deaths by instilling habits of “hygiene”. In that class, racist and upper caste influenced context dais were constructed as “dangerous”, undermining the legitimacy of the only caregivers who served the vast majority of women in India (Forbes 2005: 79-100). The language, content and institutional arrangements were not only alienating but also disregarded their knowledge and skills (Van Hollen 2003). Nevertheless, the Bhore Committee Report (GOI 1946) recommended integrating trained traditional dais into the health services. The government of independent India implemented this recommendation in 1952, taking UNICEF’s support to supply delivery kits. In the mid-1960s, attempts were made to mould TBAs as motivators for family planning, but this failed. The overall dai-training approach continued to treat them as illiterate, superstitious and unhygienic. The content still focused on cleanliness and hygiene, ignoring the class and caste correlates of the patients they were attending to; besides the training was conveyed in inaccessible language (Narayana and Acharya 1981, cited in Jeffery 1988). The paltry sum of Rs 2 to which they were entitled for each “case” referred to the antenatal care (ANC) remained unpaid for years (Jeffery 1988).

However, since 1990 interest in TBAs has waned because of the lack of hard evidence to show that trained TBAs can reduce maternal mortality. While in 1992 the WHO promoted integration of TBAs with modern childbirth care systems, by 1997 it shifted its focus and began promoting “skilled birth attendance for all” (WHO 2005). Now TBAs are to act as “link workers” to skilled birth attendants (nurses, doctors), not as primary care providers (UNFPA 2004).

It is a rude shock that the three decade-old policy of training dais to enhance maternity care has been reversed rather than re-structured within a comprehensive health governance framework. It must be admitted that the training itself had stopped dais from intervening in difficult situations, forced them to refer women to non-existent facilities, and taught them unsafe practices for “safe delivery” like the use of rubber sheets. The training neither dialogue with the indigenous knowledge systems, including the formal Ayush systems, regarding childbirth care nor did it provide instruction in emergency obstetric care. The state tried to use dais to do tasks undone by health professionals.

Evidence of ‘Effectiveness’ of TBA Training: A critical debate concerning the inclusion of dais in the formal maternity care system focuses on “whether dai-training is effective or not” in reducing neonatal and maternal mortality. But the evaluation of dai training is oblivious to the fact that there are certain age-old and effective skills in promoting the welfare of mothers and infants used by the dais, despite the training imposed upon them. Without any serious study of practices employed by dais, the multi-factorial problem of maternal mortality is still largely reduced to one of poor hygiene. Health administrators imagined that by training dais to wash their hands and adopt the “five cleans” many women’s lives would be saved. With this expectation, dais were thrown into the deep end with no emergency obstetric services in place. When maternal mortality rates did not reduce, the experts decided that dais were ineffective, unaware that women die in childbirth from causes dai-training has never been expected to address.

In any case, the meticulous “meta-analysis” of evidence by Sibley and Sipe (2006), based on 60 studies from around the world is remarkable on several counts. Its framework, while contained within the bio-medical paradigm, is still broad and it comes out with a limited, positive recommendation in favour of TBAs. The authors conclude that, in settings characterised by high mortality and weak health systems, trained TBAs can contribute to meeting millennium development goal (MDG) #4 through participation in key evidence-based interventions. They see TBAs
having a meaningful role in the current policy climate that emphasises transition to skilled birth attendance. Interestingly, a paper in the Bulletin of the WHO has challenged the “skill” of all types of existing skilled birth attendants (excluding TBAs) in several countries (Harvey et al. 2007).

But the criteria in the above study related only to interventions within the western bio-medical model, as if no other way is in existence. In fact, there have been few evaluative studies of biomedical obstetric practices themselves, as we shall discuss later.

2.1 Who are the ‘Dais’?

Our claim is that dais represent thousands-of-years-long line of experience in attending to birthing women and newborns in India and south Asia. Surprising to many, the term dais arises from British colonial usage, perhaps of Arabic origin (Van Hollen 2003: 39). In fact, dais are not the only “traditional birth attendants” in India, as there is a larger category of women, and (although rare) men too,2 who perform tasks during childbirth and afterwards, and not only in rural communities but also in urban settlements. The work may be divided between attendance during labour and birth on the one hand and the post-partum tasks of cord-cutting, immediate care of mother and baby, cleaning up and disposal of placenta on the other (Pinto 2006). In that situation collective birth attendance by relatives or experienced neighbourhood women “baby-deliverers” is followed by the arrival of a low-caste woman “cord-cutter” who performs post-partum tasks seen as polluting and “sinful” among upper caste groups.

In other parts and in low caste (dalit) homes, the dai attends the whole of labour and also performs the post-partum tasks. In Maharashtra a local midwife is known as a surin and in Tamil Nadu she is called a maruttuvachi. In much of central and north India, however, her nomenclature denotes her caste, like khawaasin (naain), chamaarin, basodin or mehtrin in Madhya Pradesh. Not surprisingly, due to the unitary notion of “dai” unacknowledged problems of communication arise in dai-training when both “baby-deliverers” and “cord-cutters” are called together (ibid: 2006). While the former may not touch the cord or placenta, the latter may not intervene in the birth itself, unless in their own caste settings. In spite of the confusion we still find meaning in use of the term “dai”. It is in accepted usage and moreover, when negotiating between national health policy and diverse local realities, it becomes a rubric for inclusion of both the diversity of practitioners and the commonalities between them.

That said, our rough estimate is of around half a million or more practising dais in India, keeping in mind the figure of 593, 732 inhabited villages (Census of India 2001) and assuming an average of around one dai per village. Today, they largely serve marginalised populations in impoverished and degraded environments, including urban slums. The majority come from dalit, adivasi and other groups socially stashed as “backward” like those formerly classified as “nomadic” or “criminal” tribes, and including Muslim communities. By and large dais are non-literate and poor women.

2.2 The ‘Dai Tradition’

Located within the broad, diverse stream of local health traditions, the “dai tradition” could be seen as the “real mainstream” of childbirth care for socially, economically and geographically marginalised communities in India and south Asia. Clearly it is separate from the ayush systems, but there is a kind of relationship. For instance, the classical ayurvedic texts offer a theoretical framework for some of the practices, concepts and language of dais, like hawa-gola, delay in placental delivery and the importance of emotional support (Chawla 1994; Singh 2006). A two-part LSPSS monograph on local health traditions of mother and childcare compares dais’ practices with therapies found in ayurveda (Radhika and Balasubramanian 1990). But this interrelationship of knowledge traditions is mediated by hierarchies of caste, class and gender. The dai tradition is marked strikingly by lower caste women’s traditional knowledge and their ethic of community-based service.

The dais’ practices are a blend of traditional knowledge, skills, experienced insights and culturally significant rituals. Helen Gideon’s (1962) narrative of a birth in a Punjabi Sikh community situates an experienced dai at the very centre, who while attending the birth speaks of the protective fire, grain, iron and water to be placed under the mother’s cot. She elaborates on the danger of early cord-cutting that would cause the placenta to rise to the woman’s heart and kill her and reflects on recently having brought life into a lifeless newborn by heating the placenta. In his monograph, Kakar (1980) states that dais treat the placenta almost as part of the child’s body. While ritually disposing it off, they recite a special mantra to protect the newborn throughout life (ibid: 44-45).

A section on “The Dai Tradition” in the report of LSPSS’ 12-state survey on mother and child health traditions discusses childbirth practices (Bajpai and Sadgopal 1996). Shodhini book (1997), which records research on selected herbal treatments for women’s ailments, briefly discusses dais and their place in communities. However, both these sources avoid the possible ritual accompaniments of the “practices”. Chawla (1994) on the other hand, elucidates in detail the dais’ role as ritual practitioner and spiritual guide for women in childbirth.

Not all authors are positive about dais. In their investigation of childbirth in India, Jeffers and Lyon (1989) virtually dismiss them as sweepers who clean up after birth, touching on culture and ritual only to condemn their ignorance. Leaving India’s characteristic diversity aside, they focus on customs in a staunchly patriarchal area of the north where even for a first birth women do not go to their maternal homes.
It is an unfortunate fact that the dais’ base of knowledge and skills has declined in many parts of the country. However, studies in south India show that the situation is not one of simple decline but of transformation. In Kerala while deliveries now take place in institutions, the midwifery tradition continues in the form of post-partum care of the mother and child including oil massage, oil baths and preparation of special herbal medications for the mother to consume. Some dais accompany the woman to hospital to provide nursing assistance. Dais’ knowledge and skills are also shaped by their exposure to biomedical institutions, by women’s demand for specific services from them, and by the quality of services and attitude of staff in hospitals towards poor, lower caste women (Ram 1991; Van Hollen 2003). At times there is also an unfortunate opportunistic syncretism in which dais liaison with quacks. In many parts of India, and notably in Jharkhand and Chhattisgarh on the request of families the dais go and bring the jhola daktar to give an oxytocin injection. Other harmful practices such as violent pressure on the dhakka (abdomen) are also encountered in some places. Many women choose the services of dais over hospitals to avoid the humiliation and ill-treatment routinely experienced, such as verbal abuse and hitting, forbidding the presence of relatives and often being left to deliver without help of either nurses or doctor. These experiences lead women to negotiate with dais and demand some of the services offered by the hospitals, and the dais do modify their practices accordingly (Ram 1991; Van Hollen 2003).

Dais’ Way of Understanding: People share various perceptions across traditional and indigenous cultures. Women and dais speak of a birthing woman’s body opening, being open and closing in terms of energy flow (Chawla 1994, 2006; Matrika 2004). This mode of perceiving is found in childbirth traditions outside of India as well, for instance, in shared reluctance to sever the cord early (Lefeber and Voorhoeve 1998: 34, 38). A close, even long-term relationship of the placenta with the baby is also a widely shared idea. When traditionally-oriented women say that early cord-cutting causes the placenta to rise into the woman’s chest, doctors find it laughable, dismissing it as evidence of anatomical ignorance. The Matrika team heard dais in four states explain that the body’s energy should be moving down and out to expel the baby and then the placenta, and if the cord is cut too early it reverses that energy flow (Matrika 2004). In ayurveda such downward and outward-moving energy is known as apaan vayu. The lack of interface between the biomedical organ-based or materialist view of the body and the traditional, non-western energy-based views is a fundamental gap in the health services.

3 Evidence-Based Valuable Practices

The who now labels as “harmful” a number of obstetrical procedures formerly viewed as “modern” and safe in the institutionalised biomedical framework. The list includes the routine use of enema, pubic shaving, restriction of foods and fluids during labour, repeated vaginal examinations, moving a woman to a different room for the second stage of labour, sustained bearing down efforts and routine episiotomy (who 1996).

At the same time several traditional childbirth practices have found scientific validity. Among them are:

Squatting and Movement During Labour: Traditional positions in labour align the womb’s vertical axis with the gravitational force. The lithotomy position (lying flat) compromises the womb muscle’s power, delivers less oxygen to the baby and prolongs labour (Enkin et al 2000). From over 1,000 childbirths in semi-sitting posture in a Maharashtra nursing home, two doctors reported good outcomes (Junnarkar and Joshi 1999).

Continuous Caregiver-Support During Labour: Meeting the emotional, physical and social needs of labouring women enhances the progress of labour and improves neonatal outcomes. When such needs are met, women require less intervention (sedatives, oxytocin, forceps, caesarean section) and experience fewer neonatal complications (Enkin et al 2000).

Perineal Massage and Support During Labour: Traditional midwifery includes oil massage of the vulva to help stretch the birth canal. Evidence supports “guarding the perineum” to prevent vaginal tears (Enkin et al 2000). It reduces the need for episiotomy (prophylactic cut and “stitches”) which increases blood loss, pain and infection risk (WHO 1996).

Delayed Cord-Cutting: Recent studies suggest that early cord clamping may be harmful for babies (Weeks 2007); a two-minute delay was found to enhance neonatal iron stores (Chaparro 2006). Dais and other TBA typically cut the cord only after the cord stops pulsating, the placenta is out and the child has cried (Kakar 1980; Lefeber and Voorhoeve 1998: 38).

Unscientific practices persisted for years because the “fathers of obstetrics” had flawed and sexist notions about women (Ehrenreich and English 1973). Potential replacement of the lithotomy position by semi-sitting postures at last validates the use of traditional birthing stools or bearing down in squatting position as taught worldwide by traditional midwives. It is astonishing that doctors could discredit and discard such methods as being the practices of “illiterate uncouth women” when, in fact, they were techniques evolved through women’s long experience (Ehrenreich and English 1973). Potu, a woman ayurvedic physician in south India, enumerates the skills of traditional midwives, e.g., enhancing weak labour contractions with herbal medicines, varying childbirth postures to give advantage to gravity, and massaging the vulva with oil to prevent tears. She states that some dais are “known to handle breech, face and transverse presentations with skill and confidence”. Moreover they do not sever the cord until the baby is fine, and to revive a lifeless baby they warm up the placenta (Potu 2000). If the placenta does not come out within 5-10 minutes even with the mother pushing, various actions are traditionally taken to expel it. Most methods raise intra-abdominal pressure, like inducing vomiting by sticking her hair into her throat, making her chew leather, etc. If this and abdominal massage (“lifting”) does not work, the cord may sometimes be pulled, which is hazardous. Some dais perform manual removal of the placenta, as also
reported from Nigeria, Bangladesh and Malaysia (Lefeber and Voorhoeve 1998).

My own experience in Hoshangabad district, Madhya Pradesh, as a young MBBS graduate opened my eyes not only to the shockingly different and compromised conditions under which dais work, but also to their skills, patience and courage.

In 1978, I was called at night to a birth attended by Gomtibai, an experienced basodin (dai of basod caste). She was old and blind and her tiny bird-bone frame appeared starved as well. The labour had already gone on for many hours. I found the baby was malpositioned in the womb (occiput-posterior lie) with its face presenting through the cervix, a situation in which caesarean delivery is considered mandatory...

Not only did Gomtibai complete the difficult delivery without a vaginal tear, she also revived the apparently stillborn neonate by heating the placenta (Sadgopal 1979).

I last met that child in 1995, then a hefty youth of 17 years.

3.1 Placenta-Stimulation to Revive a Newborn

In medical and anthropological literature there are few references to placental stimulation for reviving a distressed newborn. In Gideon’s narrative, the Sikh dai speaks of having saved a lifeless newborn by heating the placenta on a tava (flat iron pan) over burning coals with the baby held to one side in a winnowing basket. The authors of the Khanna Study (of which Gideon was part) drew from her observations to mention it in a gynaecological journal (Wyon and Gordon 1971). Then in the mid-1980s a WHO review reported three traditional treatments of the placenta (applying salt, massaging and washing) used to resuscitate a newborn in Burma (Mangay and Simons 1986). In an Indian study on traditional neonatal care practices (interviewing 910 mothers in 11 states, not including southern states), a table entitled “Measures Taken if a Child Does Not Cry Immediately” mentions only in the footnote that “others” includes “heating the placenta, etc” (Vani 1990: 78). Potu writes of dais “pumping” the placenta in warm salted water for “up to one hour” to revive a newborn. The Matrika project recorded placental stimulation from locations in Bihar, Delhi, Rajasthan and Himachal Pradesh (Matrika 2004). A three-continent WHO-sponsored review of traditional childbirth practices (Lefeber and Voorhoeve 1998) notes that, in case a newborn does not cry after birth, indigenous midwives in Bangladesh, Burma and India heat the placenta and “milk” the cord, and attributes “trampling on the placenta” to Bangladesh. From countries as far apart as Ghana and Bangladesh, Ethiopia and the Philippines, the same authors point out “practices based on the transfer of life and strength to the baby through the placenta, umbilical cord and anterior fontanelle”, and state that “the techniques employed to resuscitate a newborn child demonstrate clearly that the placenta is the seat of some life-matter”.

Between 1978 and now, we have collected reports from 17 states in India. The dais explain that the “life force” (variably termed as jeeva, praan, jaaan, atma, ushnata or garmi, etc) is contained in the placenta, so they can bring life into a newborn in this way. Besides heating the placenta on a tava (in Punjab) or a khapra (clay roof-tile, in Jharkhand), other reported methods vary from covering it with dung-cake coals (Rajasthan) or burning dry grass (Madhya Pradesh, Maharashtra) or placing it directly over a shegdi (coal stove, in Gujarat) to submerging it in warm water (Andhra Pradesh, Himachal Pradesh, Maharashtra, Jharkhand, north Karnataka and Tamil Nadu), wrapping it in a hot steaming cloth (Tamil Nadu) or kneading it with rice husk or straw with the hands (Bihar, Haryana) or the feet (Chhattisgarh).

In September 2008, I met Irudayammal, a marattuvachi (dai) of the Fernando fishing community of Tuticorin in southern Tamil Nadu, who attends deliveries both at the home and in a hospital. She said she had picked up her skills from hospital nurses, so I had no hope that she would talk about placental stimulation. Even so, I asked her what she would do if a baby were born that did not cry. She said: “After sprinkling some water in its face, I’d get the placenta out and plunk it into a vessel of warm water, rubbing the cord towards the baby’s navel…”

Just as surprisingly, she said that she had learned this technique from those nurses in the hospital! We now ponder over three reports of placenta-heating from southern Tamil Nadu that are linked with hospital or nurses’ practice.

From all these reports it appears that indigenous midwives in India and many other parts of the world have developed and carried a technique for saving newborns lives over countless millennia that is virtually unknown to medical science.

4 Epistemological Aspects of the Composite Scenario

The composite scenario of the health services – lack of multicultural and social respect, vertical programming and abandoning of the primary healthcare ideal in favour of service privatisation – comes as part of the structural adjustment accepted by the state and its elite supporters. Equally deep are two epistemological issues linking with this that limit women’s right and access to a system of comprehensive healthcare. One is the decontextualising and reductionist tendency in western thought and medical science and the other is the staunch ideology of power hierarchy, especially in India, that biases the entire social system including the health services.

Modern medicine or allopathy has a view of the human body as an organised assemblage of functioning parts, generally without need of reference to physical or social aspects in the environment. In contrast, the worldviews of “non-western” societies, each in their own terms, refer holistically to the natural as well as spiritual universe and recognise the inter-relationship between the macrocosm (outer environment and universe) and microcosms of human activity. Thus, the life in agricultural fields, forests, water bodies and even inside human bodies is linked with wider vital flows of existence where the need to harmonise is logical and just. Within these worldviews healing involves restoration of the inner and outer environmental balance (Merchant 1980; Shiva 1988).

The reductionist approach has given medicine the great advantage of focusing on minute physical details and selected mechanisms of body function. Fuelled by industrial capital, biomedicine has generated magic bullet interventions like antibiotics for treating infectious diseases. It astonishes us today by technical feats such as “routine” coronary artery by-pass surgery and in utero operations on the foetus, and through stem cells it can now promise to correct even genetic disorders. However, biomedicine’s institutional connections with capital in research,
manufacture of medicines and privatised healthcare delivery has led to a narrow dependence on technological solutions, that has long been criticised even by insiders to the system. Over-medicalisation, especially unchecked in the area of women's reproductive health, makes women's natural processes (menstruation, pregnancy, childbirth, lactation and menopause) into near-diseases. Doctors tend to see all pregnancies as “at risk” and needing medical or surgical management. Dais perceive pregnancy and childbirth differently, stressing attention to food, rest, relief of stress and centring of mind in body.

Secondly, the ideology of power hierarchy runs deep and could not manifest more strongly than it does in the Indian public health services. Sub-hierarchies of class, caste, gender, religion, disability and age interweave in a confounding tapestry of injustice against the variously marginalised. It manifests in all the medical systems, not just in allopathy. Even in the local health traditions male healers tend to assume dominance over women. Dais contend with caste discrimination as well. According to my personal observation:

Upper caste village families still called Gomthibai for births though she was blind and aged. One night I sat up with her in a brahmin household. At dawn the daughter-in-law gave birth normally to a baby girl. All three of us were being treated as untouchable, yet even in that there was a difference. Morning tea was given to me and the mother in clay cups, but to Gomthi in half a small cracked coconut shell which she held blindly. As the scalding tea poured into it and fell onto her through the crack, she cried out as if she carried centuries of the pain of mistreatment.

Taslimon Bibi was brought to us in great pain, eight months pregnant. Her belly was rock hard with no foetal movement, no heart beat; cervix not at all dilated nor baby’s head engaged. For some stomach pains her father-in-law had called a local ‘doctor’ who had given four injections of oxytocin... We had to advise them to take her to a hospital. Her father-in-law had called a local ‘doctor’ who had given four injections of oxytocin... We had to advise them to take her to a hospital.

Even in the places where staffed “institutions” exist – PHCs, maternity homes and hospitals, government and private – studies are showing that many if not most are unfit and unsafe to deal with simple complications. Sometimes they even introduce risk into otherwise normal childbirth. By and large these institutions claim to be “allopathic”. Case studies of maternal mortality in Andhra Pradesh\(^4\) show that many deaths occur “in transport” between one institution and another, with denial of care and fatal outcomes being more frequent for lower caste and poor women, as recorded by others too (Ram 1994; Van Hollen 2003). The study done by Barnes of the JSY scheme in Jharkhand for UNICEF made just this point: it has increased “institutional” deliveries but not “safe” deliveries (Barnes 2007). Women find health centres and hospitals without staff, medicines, water, electricity, bedding, etc. Many complain about the filth of hospitals. Barnes goes on to say,

The point is that the bio-medical model is all about money – not only ‘medicalisation’ but commercialisation too. This is where the dai and doctor differ enormously. Dais will deliver babies of the poor, doctors will not. It is a case of the poor helping the poor. Even though dais crib about low rates of pay, they still do deliver for nothing if needed. I do not know many doctors in private – even government – who would. And the whole exploitative nexus in healthcare and childbirth – drivers, rmps, medicine shops – they’re all out to squeeze the poor, supported by pharmaceutical companies. The dai rarely fits into this nexus – fortunately for the poor (personal communication).

In fact, social and systemic biases in reproductive health governance prevent the potential linkages of dais with the PHCs and referral system. Inexperienced health centre doctors act as “superiors” over elderly experienced dais. In remote areas dais are deterred from attending births with no alternative provided. The “jsy” scheme for institutional delivery lacks adequate PHC and referral infrastructure, and even in referral situations the continuity of care that would be possible through a dai is not entertained. Earlier efforts to link dais with PHCs through ANMs are being diluted in the NRHM. While some states still train dais, the training is still one-way without knowledge exchange. Finally, despite poor registration of births and deaths, dais are not seriously considered for strengthening the system.

With regard to the flawed government policy of promoting “100 institutional births”, Dr Arole’s team at Jamkhed in rural Maharashtra published a useful study in 2001. It evaluates the emergency obstetric care (EOC) system provided through this hospital-based community health project. It found the EOC approach “efficient and effective” at the level of obstetric outcomes and costs of care even though most births were at home (85% of 2,861). The caesarean operation rate was 2.0%. Notably, 3% of births were complicated but still attended at home (McCord, Arole et al 2001). Regardless of the exclusive bio-medical and authoritative context within which dais in the Jamkhed project work, the study shows that it is possible for obstetrical care facilities to work in tandem with dais in community-based childbirth care services.

6 Local Communities

Two topical issues of The Lancet in recent years have covered “Neonatal Survival” (March 2005) and “Maternal Survival” (September 2006), highlighting public health and medical strategies for dealing with these concerns. Unfortunately, they fail to consider existing indigenous resources and practitioners, and particularly the relevance of TBAs and local health traditions
throughout the world. Neither does “public health” in India acknowledge our own local traditions, including simple age-old home remedies, that women and marginalised communities still use effectively. Over time they have faced and resolved issues of health and illness in various and ingenious ways for which they deserve respect and recognition. Similarly, dais’ ways of care deserve much more than the discredit pronounced by allopathy standing in blind and unquestioned judgement.

Privatisation and market expansion is squeezing such resourceful communities out of health services coverage and out of existence as well. Their livelihood constraints are tightened by environmental degradation, withdrawal of state welfare coverage and loss of food security. Insufficient food, overwork, degraded environments and increasing violence all diminish poor women’s health status even before they conceive. This is the sober context of dais’ services to women today.

Most women in Tuticorin town now go to hospital for childbirth. Sitting down to talk, expert maruttawuchi Irudayammal pointed to the empty basket she had just set down after selling a headload of fish.

My livelihood is severely affected. I have to support my invalid husband and disabled son. I love attending to birthing mothers and newborn babies and people pay me well (usually Rs 500 per birth) as they don’t like to go to hospitals and (by) far prefer the care I give. But the government doctor and municipal authorities came some months back and threatened me not to do any more births in homes. Still I attend about 10 births a month, 5 in homes and 5 in hospital.

About 20 years earlier she had attended her younger sister in childbirth, who could not get to the hospital in time. Their mother, having birthed 13 children at home, told her just what to do. Then she went to learn from some nurses in a hospital, working there for a few years until she had a community practice.

In fact, Tamil Nadu’s maruttawuchis, in common with dais elsewhere, are experiencing a reduction in income from their services and child-birthing is rarely their only or even main occupation. Due to declining economic conditions in their communities, they are paid less for this work, often in instalments. Government dai-training has weakened their financial position, too, since they are now perceived as “government” employees and refused traditional payments (Stephens 1992).

The indigenous systems, rooted as they are in social institutions devoid of capital, will be able to contribute to strengthening the public health services in terms of insights and sensitivity as well as of useful health-promoting practices. With reference to maternal and newborn health there are numerous considerations such as issues of livelihood and skills of indigenous midwives, their caste and class status and their marginalisation even within plural medical systems. Working out such a possibility will strengthen the maternity services for all women.

‘Pluralism’ in the Maternity Services?
Not requiring elaborate hospital set-ups, the dai tradition challenges commercialised, medicalised pregnancy and delivery care. Legitimising lower caste women’s traditional knowledge and community-based service confronts the dominant class, caste and gender power structures and ideologies. While some long-held obstetrical views and practices, like the lithotomy position and routine episiotomy, are now found unscientific and even harmful for birthing women and newborns, their replacement by elements of traditional care is piecemeal, approved only insofar as they fit within the allopathic world-view. A deep and genuine grasp of non-allopathic patterns of thought in maternity services is resisted. By institutionalising isolated practices validated in western journals like *Lancet* and *British Medical Journal* (*BMJ*) the dai tradition will be subordinated to biomedical institutional care, robbing it of the potential it carries to challenge the status quo in women’s reproductive healthcare in our country. Hence there is a need to advocate for integration of dais along with the dai tradition, both as a body of knowledge and as an ethic of service, into the health services system.

7 Moving towards an Alternative Vision
Several community-based health groups and networks are working in different ways to promote dais’ knowledge, skills and worldview. We acknowledge some of them here.

The Matrika project, in the 1990s, explored dais’ representations of the body and their treatment modalities that draw on community customs, ritual and emotional support (Matrika 2004). Based on that research and documentation, Matrika now advocates for incorporating dais and their indigenous birth knowledge in the development of safe, culturally appropriate birthing options for women (Matrika 2004; Chawla 2006).

The Gujarath Dai Sangathan, launched in 2005 by nine non-governmental organisations (NGOs) in Gujarat, promotes dai-training and their integration in the health services. The president and vice-president of this organisation are trained traditional dais. The Gujarath government recognises the organisation and has given each dai member an identity card. The NGO constituents work within the western bio-medical paradigm, fitting the objectives within the current health policy of the government.

The Jeeva project, initiated as a collective effort in 2007, seeks to promote the dignity, knowledge and interests of indigenous dais. Together with experienced dais in three states (Maharashtra, Jharkhand and Tamil Nadu), the project aims towards creating a new knowledge base with reference to both indigenous and biomedical frameworks. It challenges top-down dai-training and the exclusion of dais and their healing modalities from the health services system (Jeeva 2007).

The Jharkhand Women’s Health Network (JWHN) is a recently formed association of women’s health and development activists that supports an initiative for organisation of dais. Another organisation involved informally with dais is the Tamil Nadu Village Health Nurses Association (TNVHA). Thus, while the government has discontinued its earlier dai training programme, civil society groups including dais themselves and some nurses are taking steps to ensure more inclusive possibilities within the maternity services.

The Role of Research
To guide the process of correction and development, research is crucial. Various streams of research might be called upon in a
multidisciplinary co-ordinated effort. Some of the questions to be addressed are:

- Historiographic: How far can we trace childbirth culture in India and south Asia? What links does the “dai tradition” have with the formal AYUSH systems? What is the root of the pollution taboo around birth and handling cord and placenta?
- Sociological: What is the diverse profile of dais (TBAs) throughout India and south Asia, and their relations with women and communities? To what degree is the dai tradition a specialised body of knowledge shared among community women?
- Epidemiological and bio-physiological (for example, placental stimulation): How prevalent is the practice and what is its association with newborn survival and well-being? How does it work at physiological level to revive a baby?
- Health Operations: How do existing “skilled birth attendants” (doctors, nurses, ANMs) view dais and what would it take for them to view dais with respect?

8 Policy Implications

Effectively integrating dais and their tradition into the formal system of childbirth care could introduce creative alternatives in policy and programmes. Linking dais effectively with the PHCs will support safe, culturally congruent, appropriate home birth services. A vast improvement in the training of dais would be called for, building a learning environment of respect for them. It means modifying the education of allopathic nurses and doctors as well so that they can learn about the dai’s skills and work with a sense of mutual respect for non-allopathic systems of medicine. Likewise, changes would be called for in the education of AYUSH physicians and nurses to scale down attitudes of superiority over dais.

In Gujarat now there is experience of special ayurvedic PHCs (also called “healing centres”). Innovative community health work has been done with dais since the 1970s, notably at Jamkhed, Pachod and Gadchiroli (all three in Maharashtra). What can we learn from experiences like this? Introducing a dynamic and integrated pluralism into the existing monopolistic public health system is a great challenge. Given the rich potential of inputs from the dai tradition and the formal indigenous systems, the maternity services can provide an ideal ground for innovation. Can we look towards experiencing an environment where the best practices are employed sustainably and appropriately in diverse community contexts?

NOTES

1. Traditional birth attendants or traditional midwives.
2. Male birth attendants are found in hilly areas, as among the Bhils of western India and the Khasi in the North-East (from personal communications).
3. From personal communication with Leena Abraham.
4. Prakashamma, director, Academy of Nursing Studies, Hyderabad – by personal communication.
5. S Srinivasan, SAHAJ, Baroda, by personal communication.

REFERENCES

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