The Newsletter | No.65 | Autumn 2013

Towards recognition of traditional midwives (Dais): The Jeeva Study

In 2005 the Indian government, under the National Rural Health Mission (NRHM), launched an initiative to reduce the number of child deaths by 67 per cent and maternal deaths by 75 per cent, in accordance with the Millennium Development Goals #4 and #5. Under its Safe Motherhood Scheme the NRHM has declared the practices of Dais [traditional midwives] and homebirths to be 'unsafe', and hospital deliveries 'safe'. Many in public health, both outside and within the formal system, do not agree with this policy. The Jeeva Study looks at the actual role of the Dais, from a dual 'public health' and 'indigenous knowledge' perspective. The study aims to build the evidence base on the Dais' contribution to the wellbeing of mothers and newborns. It also explores their critical points of interaction with other maternity care providers, the families of the women they help, and the varied communities around them.

Mira Sadgopal

The need for including Dais

Despite rapid economic growth in recent times, India ranks low as far as maternal and child health is concerned. Under the Janani Suraksha Yojana [Safe Motherhood Scheme] public health personnel and local communities are now instructed to have women give birth only in 'institutional' (hospital) settings. A young cadre of female community health workers (ASHAs) has been created to transport women to hospitals for childbirth. The Dais, however, are considered unskilled, ill-equipped and are therefore excluded. Most of the change has taken place in the last five years, with almost a 30% overall shift towards hospital births in India. But many women complain of poor quality services and delays in cost reimbursement, and still prefer homebirths. Up to now the NRHM has dismissed an alternative solution: to improve the safety of homebirths and strengthen two-way linkages between home, community and hospital through the Dais.

After Indian independence there was just limited support for the training of Dais; after 2000, the little support was withdrawn entirely. Dais were declared hazardous, despite there being no solid evidence to hold them responsible for high maternal and neonatal mortalities. Since 2005 changes have taken place in the name of making the health system more effective and accountable, but many of the benefits are questionable and, so far, no data shows that the mortality declines post-NRHM are sharper than those that occurred prior to 2005. The Government depends upon a splintered strategy of cash transfers for the poor, public-private partnerships to provide healthcare coverage, and user-fee exemption for a small number of poor families. The family debt burden, from resorting to private medical services, is high.

In Indian rural contexts, where homebirth is still largely the norm, it has recently been questioned whether removing a woman in labour to an unfamiliar hospital, and medicalising her childbirth, is really the best idea. Elsewhere, unnecessary hospitalisation during childbirth has been debated, and there is growing support for midwives rather than doctors in normal birth. Developed countries, by and large, have lost their traditional midwives; but some, like Sweden, the Netherlands and Malaysia, have developed a cadre of modern professional midwives. India has failed to do this, to which their low mortality rates are attributed.

In recent years in the West the effectiveness of some traditional childbirth practices has been acknowledged and to some extent even absorbed by modern practice, but in India the health services give the Dais little praise. The recent exclusion of Dais, along with their traditional skills and understanding in childbirth, has had deep effects. At the community level it has devalued and denied an age-old skilled tradition that is a part of community life. Very few young women still wish to learn through apprenticeship with experienced Dais. The health system itself, which could benefit from the Dais' skills and outlook, is deprived of input to develop childbirth care in a more positive and natural way. Where there is no doctor, the Dais' close contact with women and their shared social space provides innumerable opportunities for her to extend the best advice. It is something a system geared to emergency care and hospital delivery cannot provide. The cultural closeness of a birthing woman and her Dai is able to create a comfort zone that hospitals cannot.

Jeeva researchers at the Himachal Pradesh site, performing 'social mapping' with a group of women in Nalota Village, including a Dai.

The Jeeva Study

The Jeeva Study covers a total population of around 40000, distributed between four sites in the Indian states (provinces) Jharkhand, Karnataka, Maharashtra and Himachal Pradesh. It encompasses both qualitative and quantitative dimensions, looking at the Dais in their local contexts, their traditional practices in normal and complicated situations, and at the utilisation of their care (especially by the poorest). It also takes into consideration the other providers of maternity care, both formal and informal, and how they make use of Dais. Through surveys of the households and the various other care providers, and with follow-up of pregnant women, and direct birth observation when possible, the study assesses the prevalence and outcomes of 'key' practices. It also compares women's experiences of homebirth and institutional birth. It tackles issues of contrasting knowledge frameworks to bridge the gap between the Dais' traditional community-based perspective and the Indian public health services system's outlook, which is framed by modern biomedicine. Hence, through this multidisciplinary study the researchers look into the role of Dais from both public health and indigenous knowledge viewpoints, considering the Dais' multiple contributions to maternal and newborn wellbeing, the social-economic and health system dynamics surrounding them, the dependence of the poor upon them, and potentials for their formal recognition to strengthen the provision of childbirth care. While the fieldwork is still in progress, here we offer some preliminary impressions.

Household visits reveal just how reliant families are on Dais and how they are aware of the strict government policy against homebirths. They say the Dais are the only providers of such care who come when needed, and at a very low cost. They explain how much the formal provisioning of antenatal, childbirth and postpartum care lags behind the Government's claims. So usually the first choice even today is care by a Dai. Those who opt for a hospital birth say that any serious difficulty can be handled there, blood can be given if needed and so on. But the Dai stays in touch with the family and reliably reaches the home when the woman goes into labour. If the woman goes to hospital, the Dai often goes along. During in-depth interviews with the Dais they explain that they do this work out of a sense of responsibility towards the community and with a kind of spiritual commitment to the women in their time of need. Their long practical training and learning by observation is critical. By living in the communities they serve, their social interaction across caste barriers is a rare example of female mobility in a patriarchal culture.

Complications faced by Dais include amniotic fluid leaks, a small birth passage, eclampsia, breech presentation and transverse lie, the umbilical cord around the neck, delayed or retained placenta, bleeding before and after birth, baby not breathing, and so on. Experienced Dais tell of how they have handled complications when medical backup was nowhere to be seen. Depending on accessibility, the Dais now do refer to institutions in accordance with the law, but it is sobering and significant to consider what risks are involved for women on the way to, at and beyond the first institution reached.

The Jeeva study also looks at local medicines and dietary elements as they affect pregnancy, childbirth and postpartum and other conditions of women and babies. The remedies include herbal, animal and mineral ingredients, many but not all finding resonance in the therapeutic principles of Indian systems of medicine (Ayurveda, Unani and Siddha). Sometimes their use includes reciting a mantra. Some blend seamlessly into hands-on procedures and manoeuvres. At one site, the Dais sum up their skills simply as "holding the belly", but we find that they subtly and rhythmically coordinate their hold with womb contractions. They perform oil-massages at various stages, simultaneously to diagnose and to heal. There are various uses of heat, different positions adopted, and many ways a Dai puts the woman at ease or urges her to exert her strength in giving birth.

The study of local terminology is also helping to enter deeper into the Dais' world. Many words related to the woman's body, conception, pregnancy, childbirth and post-birth, reflect nature and farming. For example, words for the vulva or perineum evoke land, growing plants, flowers and seeds. Rituals that accompany these events typically utilise seeds or grains, and so on. Exploiting the potential of inter-relations between the existing local health services – government, private and traditional, including Dais – demands such epistemological engagement and acknowledgement.

Linking Dais with the formal health system

The Jeeva study acknowledges an important traditional resource – the skills of popular Dais – in a context of acute shortage of personnel, especially in backward areas. It argues for letting the Dais continue their work in co-ordination with the formal care providers and envisions safer childbirth through strengthened community-based birth attendance with appropriate support from the formal health care system. The inclusion of Dais in public health can strengthen the services and contribute to the survival and wellbeing of mothers and newborns. The Dais should be recognised, their ways respected, their reporting taken seriously, their advice heeded – in short, the responsibility of caring for childbearing women should be shared with them, to ensure a seamless continuum of care between home and hospital.

Including Dais and their traditions in the expansion of formal childbirth care not only addresses the important concerns behind Millennium Development Goals #4 and #5 with their focus on survival and wellbeing of mothers and newborns, but also advances Millennium Development Goal #3 (women's empowerment) as the female Dais negotiate space within the healthcare system. This will be possible only when the other female health workers at the bottom of the formal system learn to respect and relate to the Dais as equal partners – a simple word, but a huge social and epistemological challenge to the Public Health Services in India today.

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Note

1 The Jeeva Shepherds are thankful for their 4 project partners: *Jan Chetna Manch - Bokaro* in Bokaro District of Jharkhand, *Janarth Adivasi Vikas Sanstha* in Nandurbar District (Maharashtra), *Society for Rural Development & Action* in Mandi District (Himachal Pradesh), and *Mahila Samakhya Karnataka* in Bellary District (Karnataka); grant-in-aid from the AYUSH Department (2011-13) and a co-funding grant from the ICICI Foundation for Inclusive Growth (2011-14); grant administration by the Centre for Women's Development Studies (CWDS), New Delhi; and field data collection by four teams of researchers and translators, with data management and overall coordination from Delhi by a dedicated core team.