

Advocacy for Recognition of the Dai (India's Traditional Midwife) - A case presentation by CHETNA

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Abstract

Indigenous midwifery is one of the finest examples of traditional wisdom and skills possessed by women and is learnt through observation and years of apprenticeship and has been transferred from women to women through the generations. Since ancient times, pregnancy and childbirth have been in women's domain. Women give birth at home with the support and encouragement of the elderly, experienced and skilful women of the neighbourhood. In most traditional rural societies in India, women still continue to practice their wisdom to bring humanity into the world. Men are sometimes called in to give a helping hand in the case of difficult births or to provide support.

In most of the rural remote, tribal and urban slum areas of India, the Dai's role is central to facilitating birth. The Dai mentioned above is India's traditional midwife, also known as dai-maa in Hindi, daayan in Gujarati, suin in Marathi, Patbichhi in Malayalam and so on. The word Dai stems from daayi – meaning "one who gives". The public health system refers to the Dai as a "traditional birth attendant" (TBA).

Since maternal mortality has stagnated across the globe, and India ranks among the countries with a high maternal mortality rate, there has been a shift in the global world-view for institutional childbirths with skilled attendants. As a result, the role of the Dai is perceived as she who provides facilitation institutional births. With 65% of births in India taking place at home and with 41% of these births being assisted by Dais and looking at the present health infrastructure and women's access to healthcare services, the best possible strategy is to recognize and strengthen the role of the Dai in safe home births, aptly supported by functional essential obstetric care.

Overlooking Dais because they cannot reduce maternal mortality is a direct threat to indigenous midwifery skills. The danger is therefore marginalization of Dais, who are available, accessible and affordable and are usually from the lower socio-economic strata of society. While skilled attendance at the time of delivery could save the lives of 15–20% of the women who develop complications, there is a danger of depriving 80% of women of the woman-centred, culturally sensitive, available, accessible and affordable obstetric care provided by Dais. Also, the danger lies in marginalizing a whole range of traditional, Dalit, tribal, Adivasi and poor women from their age-old profession.

For the past two decades, CHETNA has been actively involved in ensuring safe home births by strengthening the Dai tradition. As the result of a decade long advocacy effort, seven Dais and CHETNA along with leading NGOs of Gujarat have formed a Dai Association that has been recognized by the Government of Gujarat. The Association works towards the recognition of Dais at the state and district levels and has plans to expand into other states and countries. This paper looks into the salient features of the Dai tradition, reviews the efforts made by the public health system and NGOs and describes the advocacy efforts being made towards the recognition of Dais including the Dai Association, Gujarat.

Introduction

In most South Asian countries, in rural as well as urban poor communities, around 65% of childbirths take place at home and most are attended by traditional birth attendants (TBAs), or indigenous midwives widely known as “Dais”. The Dai’s role in childbirth has been recognized by the community and is one of the finest examples of traditional midwifery skills passed on from one woman to another. She is the only traditional healer recognized for maternal and newborn care by public health systems.

However, as global eyes turn towards stagnated maternal mortality and the need for institutional childbirth and skilled assistance at the time of delivery emerges as the only strategy for reducing maternal mortality, traditional Dais are being pushed towards the periphery thereby de-recognizing their traditional skills of childbirth.

Global policy focuses on creating new skills rather than on training and supporting the virtually illiterate traditional Dais. On the whole, Dais are intelligent, strong in character, trusted in their communities and experienced in childbirth. Naturally, the question arises, isn’t it sensible (till a cadre of skilled birth attendants [SBAs] is built up) to support, strengthen and optimally utilize this existing resource pool of TBAs?

Ample evidence in India, South Asia and other countries indicates that, when supported by functional essential and emergency care services, Dais can significantly contribute to reducing maternal and neonatal morbidity and mortality. Dais can be key to linking women’s homes with essential and emergency hospital care.

Communities have needed the village midwife or Dai since time immemorial. Traditionally, her services have been part of *jajmaani* and *balutedari* (feudal labour-exchange systems in North and West India). In her relationship with village women, there is mutuality, a cultural consistency and an appropriateness of skills. Easily accessible to women, knowing their concerns, she provides care during childbirth and afterwards. On the other hand, traditionally Dais come from the lowest castes and hold no social power.

While skill transmission among barbers, dhobis, carpenters and leather-workers is “male”, the handing down of midwifery skills is “female”. Typically passed from mother-in-law to daughter-in-law, the occupation has stayed unstructured, never growing into a “profession” in contrast with the male trades. Now more than ever, it faces suppression and extinction by gender power politics at all levels. The government has ambivalently wooed Dais through training programmes, leaving them when it comes to support services. Their age-old skills are eroding.

This paper aims to develop an understanding of traditional midwifery and its role in providing women-centred, gender-sensitive care at home and also in linking homes to health facilities.

The Indian context

“In a rural village in Barmer, Rajasthan, Rasi was giving birth for the sixth time. During her pregnancy, she had not received any care. When she went into labour, the village Dai was called. In the midst of her labour, she started to bleed. The Dai immediately asked her husband to arrange for a vehicle as Rasi’s condition was critical. He

walked for half an hour to reach the nearest town where the nurse stayed. Somehow he managed to find her, but by the time they had both walked back to Rasi's village, it was too late."

As told by Rasi's sister-in-law to an NGO worker in Rajasthan.

The above real life incident depicts the reality faced by most women of the remote, rural areas of Rajasthan, one of the states with the highest maternal mortality rate (MMR) estimates (667/100,000 live births), and is representative of similar situations in other states. Community needs assessment in six rural, desert districts of Rajasthan indicates that

- 81% of births were conducted at home.
- Dais conducted 75% of the deliveries, auxiliary nurses and midwives (ANMs) conducted 9% and family members conducted 7%.
- On an average, the distance to the nearest Primary Healthcare Centre (PHC) ranged from 1.5–50 km, i.e., about 20 minutes to 6 hours away.
- The distance of the district hospital, where emergency obstetric care was available, was 13–100 km, i.e., 1–7 hours away.

In most of the rural remote areas and urban slums of India, home births attended by Dais are a reality; institutional deliveries seem a distant reality, as the infrastructure that would be required is immense. The need of the hour is to make home births safer while working towards improving infrastructure. In the Indian context, the Dai is a critical actor in making home births safe as she is available, accessible, affordable and an accepted resource at the community level.

Who is a Dai?

The Dai is India's traditional midwife, also known as *dai-maa* in Hindi, *daayan* in Gujarati, *swin* in Marathi, *Pathichhi* in Malayalam and so on. The word Dai stems from *daayi* meaning "one who gives".

The socio-cultural profile of the Dai

The village Dai is usually a middle-aged woman of Dalit or oppressed caste and is poor. Certain subcastes of oppressed and Dalit castes perform the role of the Dai. The Dai is a part of the *balutedari* or the *jajmani* system, by which trades in Indian societies have been traditionally arranged. In many states, women of the *naai* (barber) caste may perform the Dai's role, perhaps because of their connection to the surgical trade and instruments. Likewise women of the *chamaar* (leather-worker) and the *basod* (bamboo weaver) castes are Dais. Among Rajput *Thakurs*, elderly experienced women of the extended family support woman during childbirth; Dais are often called upon to cut the cord and remove the dirt. In most communities, she is an integral part of the community health and healing systems.

Most Dais have not received any formal education. Hence, they are usually illiterate or barely literate. But their learning from life experiences provides them the necessary skills through apprenticeship and experience.

A Dai usually has the experience of giving birth to several children of her own. As a young girl, she accompanies her mother, mother-in-law or an elderly aunt and

learns while observing the process. Gradually, she starts assisting, and later on, when she gains confidence, she delivers a child on her own, with another learner by her side. Usually, the Dai has 5–10 years of informal learning exposure before she practices on her own.

“My *kaki sasu* (husband’s aunt) used to do this work. When I got married, she assisted me during the birth of my children. I got interested and started accompanying her. She used to tell me how to manage labour, and I used to do the odd jobs. Then, she used to let me handle the labour at various stages. She once asked me to conduct a delivery in her presence, as she was not feeling well. This gave me confidence, and from then onwards, for the past many years now, I have been doing this work.”

A Dai from rural Gujarat

However, some Dais start the practice earlier when they are compelled to support a woman in crisis and then continue the work in interior communities as a philanthropic gesture.

“On my way to the nearby village, I saw a woman going into labour by the roadside. I panicked but could not leave her in that state. I am a mother and have the experience of giving birth I told myself. I supported her and took her to a secluded spot and assisted her. I used the clean end of my sari to tie the cord and a blade of grass to cut it. The mother and her baby are hale and hearty even today. From that moment, I got the confidence to conduct deliveries. I decided to help women of my villages in their hour of need and have been doing so for the past ten years.”

A Dai from Gujarat

Some take up this work because of their association with an NGO.

“SARTHI, an NGO, trained me as a barefoot veterinary worker. When I started giving treatment to cattle, I realized that there were no trained Dais in my village. The PHC is 15 km away from my village, and women had to go to the CHC (community healthcare centre) in neighbouring towns when they were in a critical condition. Women and children used to die on their way to hospital. I participated in the Dai training programme. I went to the PHC and CHC to enquire about their services. On the day the ANM comes to our village, at the fixed time, I collect all the pregnant women for check-ups and immunization. I also motivate them to go to the Anganwadi and eat the food supplied. I also participate in the monthly meetings at the PHC and collect iron tablets and Disposable Delivery Kits (DDK). Through my efforts, I have been able to motivate women to avail the services and healthcare provided by the

government. Earlier, they were aware of the services but did not avail them. After I started this work, they have started availing them.”

Chanchiben, a Dai from Gujarat

Most Dais work as labourers or in agriculture. They support women in labour as a duty towards their communities and to assist women in need. The communities happily reward them with gifts like a sari, grains, coconuts etc. and, at times, a little money. Most of the time, it is left to the families to decide what they would like to provide on the basis of their capacity. Many times, the Dais wait for hours together without even a cup of tea and usually end up receiving hardly any money. At some point of time, a Dai may negotiate and demand remuneration for her services. Hence, most Dais remain in poverty. With more and more families reducing the number of births, the Dais are losing business, which is affecting their meagre income.

The Dai speaks the same language as her patients and is an integral part of the religious and cultural system of society. She enjoys the full faith and trust of the village women with regard to their own health and that of their children's. When any problems related to gynaecology arise, village women consult the Dais. They possess midwifery skills and are trusted counsellors for women during pregnancy and delivery and for the care of newborns. In the majority of cases, the Dai is the only person available at any odd time and all the time, round the clock in the village.

“We do this work because it is *dharam ka kaam* (religious work). We walk long distances, wait for hours together and risk our lives to go at any time to toil with a woman. Still, we get very little money. If the family is poor, we may not even get a cup of tea. Some families give us some grains or old clothes, whereas some give us Rs.50–60.”

A Dai from the State of Maharashtra during a healers meet organized by CHETNA.

“I am a skilled person. I have delivered most of the young people of this village. The entire village respects me and listens to my advice. Once, there was this family whose daughter was very young and weak. My assessment was that she would not be able to take the pain. I advised her to go in for a hospital delivery. Her parents agreed, and today she is happy with three daughters.”

A Dai from rural Gujarat

Ayurveda, the ancient science of life, one of India's formal, institutional traditional health systems, strongly recommends birth in a home that is equipped to take care of birth and birth-related concerns and with the help of experienced and wise women; this indicates the critical role of women during childbirth.

About the Dai's healing knowledge and skill

Complaints of dizziness, lumps in the body, morning sickness, broken hearts, internal disagreements and worries, birth of a calf, property problems, delayed labour and so

on are handled by Dais. Women and men confide in her and consult her with varied problems. Most women experience her warmth and the deftness of her skills during a trying period in their lives.

The Dai performs elaborate to modest ceremonies to invoke the goddess of birth and prays for a safe delivery, to pacify a violent husband and to engage him in caring for the mother and child.

A Dai is the original practitioner of comprehensive medicine. According to anthropologist Karen McCarthy Brown, she combines the skills of a medical doctor, psychotherapist, social worker and priest. Dais heal women and men in the context of their families and society, taking into account the cultural, physical and spiritual contexts.

“As soon as I enter the house of a woman in labour, I ask the family to bring warm water to wash my hands and feet. Then, I ask the women of the house to unlock all the locks in the house. (This symbolizes the opening of the cervix). I assess the woman’s condition and inform the family accordingly. I also ask the woman in labour to separate a mound of flour with a coin (symbolizing separation). Then, I coax the woman to squat and then to bear down. I also massage the cervix and the passage with edible oil and hold the baby carefully when it pops out.”

A Dai from the State of Uttar Pradesh

The community believes that the process of childbirth is understood not only in physiological terms but is also woven in the cultural and religious ideologies of women and communities. Childbirth is viewed as not just a physical process but also as an act of bringing a soul to the earth. Special goddesses facilitate childbirth processes. Each community has its particular deities whose blessing expedites childbirth and protects women.

It is within this matrix that the Dai works, not only as an accomplished herbalist and a childbirth facilitator but also as a ritualist. She adopts various rituals to invoke the goddess of birth and seeks her blessings for a safe birth. She functions as a mediator of the divine energy, channelling energies or ancestral knowledge. Labour therefore is a process of opening up and separating two souls and various rituals are performed accordingly. For example, the Dai may ask the women to undo their plaits or to unlock all the locks in the house or to separate a mound of flour in to two using a coin.

Rituals are helpful in facilitating a woman’s labour – imagery acts as an interface between mind and body, bringing what in physiological terms is considered an involuntary process at least partially under conscious control (Chawla, 1994).

The client-woman is actively engaged in childbirth processes through dietary modifications during pregnancy and through rituals and rigorous regimens during labour. These are measures for the woman in labour to connect herself with the internal and external environment. One would expect love, respect and benevolence from the community for carrying out the noble work of assisting in childbirth. But many times, the Dai is down-trodden by caste and tradition, though humanistic values bind her to serving others. Her work is often taken for granted, and she goes

without recognition or reward and sometimes with insults. Often her work is ridiculed and her role and services ignored.

Dais are thus a rich resource available at the village level to address women's health concerns. On the one hand, they possess the necessary midwifery skills, and on the other, they command the respect and trust of the community. In addition to this, they are the only persons available at any odd time and all the time round the clock in the village. Being a resident of the same village, the Dai knows each family personally and the status and history of most of the women of the village.

“We have to be ready to go out at any time. We face the additional threat of violence from some village people, particularly when we protest. Many times, after a long day, when we are about to retire for the day, a call comes. At night, it is even more dangerous as the area is full of snakes and there are no lights or roads. At times, I ask the person to bring a cycle. If he/she cannot, I have to walk for miles.”

Dai (*suin*) from a rural area in the State of Maharashtra

The evidence base

Various international authorities have emphasized that integrating Dais into the public healthcare system is important for community health.

- “Where the use of TBAs is strongly rooted in local customs, it is beneficial to:
 - Train TBAs to avoid harmful practices during delivery (and use good practices), recognize danger signals and refer complicated cases to higher-level care.
 - Establish or strengthen links between TBAs and the formal maternal healthcare system
 - Ensure that health centres and hospitals will accept referrals from TBAs.” (Anonymous, 1998)
- “Where TBAs account for significant proportion of deliveries, safe motherhood programs should include activities aimed at providing adequate supervision and integrating them in to the health system.”(Anonymous, 1997).
- “The traditional midwives can provide culturally appropriate nurturing in the community setting; offer a first line of link with the formal healthcare system. However, Dais alone in absence of back up from a functioning referral system and support from professionally trained health workers cannot ensure safe motherhood.” (Anonymous, 1999.)
- Experiences from Sri Lanka, China, Cuba and Malaysia indicate that establishment of community-based maternal healthcare systems comprising pregnancy, delivery and post- partum care and a system of referral to a higher level of care in the event of an obstetric complication is the key to ensuring safe home births. In Bangladesh, services of a trained midwife (not a Dai) have been useful in making some differences in maternal mortality.

- China (rural) and Fortezela, Brazil, were able to bring their MMRs to 115 and 120, respectively, using the following model:
 - Lay provider recognizes complications
 - Family or provider organizes access to essential and emergency obstetric care
 - Functioning emergency obstetric care available

Role of the Dai in home births

Dais provide affordable basic maternal care at home

In half of the major states of India – Assam, Bihar, Haryana, Himachal Pradesh, UP, Kerala, Punjab, Rajasthan – the total cost of treatment to the patient (excluding cost met by the government) is higher in public hospitals than in private medical care. While public institutions provide normal delivery care at nominal or no cost to the user, the opportunity cost (Rs.57 per day per patient (source: NSS, 1992,418,437,516; Independent commission on health in India) makes deliveries in a public institution costly. The poor utilization of public services further increases the cost of care. Loss of daily wage, transport, supplies and other costs to the user make institutional deliveries almost unaffordable.

Dais are available in the village. They are the critical link between the community and the public healthcare system. If trained properly, the Dais can provide essential obstetric care at home, leading to minimal disruption in the client's day-to-day living. A normal home delivery by a trained Dai could cost anywhere between Rs.100–500. Hence, strengthening the system of Dais is an affordable strategy towards safe home births.

Dais supplement the human power needs for safe motherhood

Considering the population covered by a PHC in rural area, it can be estimated that the PHCs conduct 900 deliveries per year. There is a chance that complications will occur in 15% of these. Therefore, a minimum of 750 normal and 150 complicated deliveries are estimated at the PHC. Most PHCs in India are hardly equipped to cater to this load.

There are more than six lakh Dais in India, assuming that there is one Dai per village, and they facilitate 80–90% of all childbirths in remote, rural areas and about 40% of those in urban slums.

In a situation where distances to public healthcare and availability of trained gynaecologists and obstetricians in rural, remote areas are a concern, Dais are the human power resource of public healthcare.

Dais help in reducing delays in referrals

The difficult geographical terrain, the socio-economic-cultural context and poor infrastructure obstruct easy and timely access to PHCs, particularly during emergencies.

Dais are accepted by and respected in communities. They play a critical role in mobilizing the community when complications occur and, if empowered through

training and supporting services, can help in early identification of complications and ensure timely and appropriate referrals.

When supported by functional, efficient, sensitive referral services, training Dais has resulted in identification of complications and ensuring early referral, thereby reducing the number of deaths due to two – identification of complications and timely referral – of the three delays.

“Rama was giving birth for the third time. A local Dai facilitated her labour, and she gave birth to a beautiful baby. Immediately after the delivery, she started to bleed. The Dai, alarmed, asked the family to rush for a vehicle and shift her to the hospital, which was an hour’s journey away. Meanwhile, she started giving Rama fluids and reassured her. She was trained to keep the patient’s foot end elevated, which she did, and she wished she could somehow stop the blood from flowing. Rama’s family was running helter-skelter for a vehicle and half an hour’s effort yielded no results. Luckily for Rama, a local NGO came for a visit. Realizing the threat to Rama’s life, they readily lent their vehicle. Rama’s life was saved.”

A case study from Alwar district in rural Rajasthan

“I was trained as a Dai by a local NGO. A family called me for a consultation when their daughter was seven months pregnant, for the first time at the age of 17. A look at the daughter and I could make out that she was very weak. I informed the family about the care to be taken and advised them to go in for a hospital delivery. Respecting my suggestion, the family did so, and their daughter and her baby are healthy and happy.”

A Dai from a rural area of Gujarat

“I have undergone training organized by my organization as well as by the Primary Healthcare Centre. They taught me about cleanliness and the other conditions that pose a threat to a woman’s life. When I come to the hospital, the doctor always greets me, enquires about my work and asks whether I faced any problem in the field. I feel good. When the ANM comes to my village, she comes to my house first and then we go together for a visit to the women that I have identified. Sometimes, I call the women to my house at an appointed time and we discuss pregnancy care and numerous other things. The nurse is very friendly and comes regularly and takes good care of my women.”

A Dai from rural Gujarat

Dai mobilizes the community for safe motherhood

Women die while giving birth not only because of medical complications but also because of the cumulative effect of social injustices, which begin with female foeticide and infanticide and include teenage pregnancies, botched abortions, too many

pregnancies too close together and frequent pregnancies throughout the reproductive years.

For example, cephalo-pelvic disproportion can be treated medically, but to prevent it, there is a need to ensure that girls get proper nutrition right from childhood. This calls for action to eliminate gender biases at the community level.

As Dais are socially and culturally accepted and as they help communities and women during their critical periods, they enjoy the status of a power figure. They therefore command the respect of the community and can become an agent for social change.

“I was a contract labourer in a nearby quarry. The need to do something to prevent numerous women and children from dying during delivery prompted me to participate in the Dai training programme organized by my NGO. I started working as a Dai. Women and men were not aware of the care to be taken during pregnancy, childbirth and after childbirth. I conducted meetings to impart education on these aspects. Now, families in my village accept immunization. Earlier, there were many food taboos, but now the families have changed and pay more attention to women’s nutrition.

Earlier, the ANM was irregular; I went to the PHC and informed the medical officer about this. He assured me that from now onwards, the ANM would come regularly, but that I would have to co-operate with her, I went back and conducted a community meeting. I informed the community about my role as a Dai and also about my discussion with the Medical Officer. They took this as a positive step.

Now, the ANM comes to our village regularly, and all the women and children get immunized as per schedule. Women get iron tablets and DDKs regularly.”

A Dai from Panchmahal district of Gujarat

CHETNA’s efforts

The Dai is looked upon as a social resource, available, accepted, accessible and affordable to most women in remote rural and tribal communities. Hence, efforts are being made to strengthen this resource base by capacity building.

Study of Dai practices

In collaboration with the Lok Swasthya Parampara Samvardhan Samiti (LSPSS) and 26 field-based NGOs, CHETNA conducted a study of traditional practices during pregnancy, labour, after childbirth and for newborns and child care. Around 2500 women and Dais from 12 states of India participated in the study to share their traditional knowledge and wisdom.

The study clearly indicated the positive role played by traditional practices and the Dai tradition in strengthening the health of women and children, and at the same

time, it laid emphasis on the need to provide supporting primary healthcare and referral services.

Training of Dais

During 1987–90, CHETNA trained over 1000 Dais from the states of Gujarat, Rajasthan, Uttar Pradesh and Andhra Pradesh. This was done in collaboration with local NGOs who then took on the task of follow-up and monitoring. A general feedback of the training was given in terms of the following:

- Increased acceptability and credibility of Dais in the community
- Increased self-confidence and self-respect
- Utilizing positive traditional practices during pregnancy and labour, viz., birthing posture, herbal remedies' massage and so on.
- Adopting aseptic measures during labour, viz., scrubbing hands, cutting nails etc.
- Linking up with ANMs and health centres for care and referrals
- Addressing reproductive health problems of women and men

These experiences reflected three strong areas for intervention, viz.

1. Recognition of the Dai by the governmental healthcare system and integrating her with the primary healthcare system.
2. Understanding Dai practices from a positive viewpoint and strengthening her knowledge on the basis of traditional medical systems like Ayurveda.
3. Building capacities of trainers, supervisors and managers of health programmes to develop a positive approach towards the Dai tradition.

Training of trainers (TOT)

The capacities of 50 trainers were strengthened. These trainers then conducted Dai training programmes in their respective organizations. Efforts were also made to strengthen the capacities of government employed trainers so that they could implement an effective Dai training programme.

This strategy has enabled organizations and individuals to view Dais from a positive angle and integrate them in existing health programmes.

Long term linkages

Long-term involvement with organizations implementing the Dai training programme was forged and efforts were made to support and strengthen their activities. In Rajasthan, these include URMUL, Falaudi; Sewa Mandir, Udaipur; CUTS, Chittorgarh; Astha, Udaipur and CASA, Udaipur, and SARTHI, Godhra and DHRUV, Dharampur in Gujarat.

These efforts enabled appropriate implementation of Dai training programmes and strengthened NGOs abilities to train Dais for women's health and development.

Developing teaching aids

In order to support trainers imparting training to Dais, CHETNA has developed a multimedia training kit, which is useful to impart training to Dais, and it has been widely distributed.

Sharing and networking

CHETNA has been sharing its experiences of Dai training at various national and international forums and advocating for their recognition in healthcare systems, programmes and policies. Related reports and documents are shared extensively at the national and state levels with NGOs, academicians and GOs, and links have been established.

Advocacy efforts

CHETNA along with its partners is advocating for the recognition of the role of Dais in safe home births. This includes presentations and showcasing the Dai tradition at national and state level policy meetings, media advocacy, developing an advocacy paper and building capacities of community based organizations to implement evidence based Dai training programmes.

CHETNA is also advocating for safe home births at the international level through the People's Health Movement and in the South Asia region. A brief description of the efforts being made is discussed below:

1994–2000: Global environment changed focus from maternal and child health to maternal mortality, and the role of the Dai in childbirth was marginalized.

A state level meeting of civil society members was organized in the year 2000 where advocacy for the recognition of Dais was identified as something that needed to be done.

A Gujarat state level meeting of civil society members was held to plan the advocacy strategy for the recognition of Dais.

State and regional activities were organized in Gujarat to highlight the Dais' work.

On 11th April 2003, National Safe Motherhood Day, a Dai mela and consultation was organized in collaboration with the Government of Gujarat.

The state's Department of Health and Family Welfare reviewed the curriculum of the Dai training programme and recognized the Dais trained by three NGOs in Gujarat.

A state level task force was formed to look into Dai and safe motherhood issues.

A policy dialogue was organized by SUMA, Rajasthan White Ribbon Alliance on the Role of the Dai in safe home births at Jaipur on 14th November 2003.

At the National and International level

Presentations were made on recognition of Dais at the National and International People's Health Assembly in the year 2000.

Dais were provided a forum to share their experiences and concerns on their role in home births at a national consultation on safe home births organized by the White Ribbon Alliance, India (WRAI) in 2001.

Some Dais were given awards for their role in maternal and newborn healthcare during the International Conference on Saving Mother's Lives organized by WRAI in October 2003.

A national level dialogue was organized on the role of Dais in linking homes to hospitals, May 2004.

In July 2004, the Department of Health and Family Welfare called a meeting of civil society members to discuss Dai training in the state.

The state level task force has taken up the issue of organizing Dais, and a series of consultative meeting were held (August 2004–July 2005).

The Dai Association, Gujarat was launched on 11th April 2005 in the presence of 1500 Dais, the minister for health and officials of the Department of Health and Family Welfare.

The Dai Association, Gujarat was registered on 9th June 2005 as a legally registered charitable society.

The Dai Association has a membership of about 5000 Dais and 12 NGOs from the state of Gujarat, India. It was founded by seven Dais[‡] and seven lead NGOs^{§§} of Gujarat, India, who had been working on safe motherhood issues for more than a decade and a half. The president and vice president of the Dai Association are Dais themselves, and it was launched on 11th April 2005 (National Safe Motherhood Day) in a meeting with the Department of Health and Family Welfare, Government of Gujarat, and 1575 Dais from 15 districts of Gujarat.

The goal of the Dai Association is to work towards improved maternal and newborn health in the state of Gujarat. The objectives are to

- Organize Dais and to advocate for their recognition as a link between the community and the public health system;
- Work towards development of traditional midwifery standards and
- Enhance the capacities and skills of Dais.

Some of the critical outcomes of efforts made by the Dai Association, Gujarat are given below:

Advocacy for recognition of Dais

- A Government Resolution was issued (August 2005) and sent to all 25 District Health Officers of the state recognizing the role of the Dai in maternal and newborn health as well as in other national health programmes. The state has provided a copy of the same to the Dai Association (TAPW1020001076-GH).
- A state directive to the District Health Officers of Gujarat has been issued to provide remuneration to Dais: Rs.25 for normal deliveries and Rs.50 for referrals. The Department of Health and Family Welfare, Government of Gujarat, is considering giving this amount to the Dai Association for reimbursement to Dais (December 2005).

[‡] Babiben (Dholka); Champaben (Jhagadia); Leelaben (Surendranagar); Vanitaben (Valsad); Ramilaben (Vadodara) Maliben (Panchmahal); Parvatiben (Radhanpur).

^{§§} Bhansali Trust, Radhanpur; CHETNA, Ahmedabad; Deepak Charitable Trust, Vadodara; SEWA, Ahmedabad; SEWA Rural, Jhadagia; SARTHI, Panchmahal; SWATI, Surendranagar.

- The state has agreed to provide a matching grant to the core fund of Rs.1,05,000 (US\$ 2400) that was contributed by board members of the Dai Association (November 2005).
- The state has agreed to provide Rs.2100 (US\$ 46) from the total capacity building cost of Rs.5000 (approximately US\$ 100) per Dai for capacity enhancement. Dai Sangathan has agreed to raise a matching grant (November 2005).
- The Department of Health and Family Welfare, Government of Gujarat, held a meeting with District Health Officers on 24th December 2005. The Dai Association was invited to discuss ways and means of strengthening co-ordination with the district health department. A common consensus was obtained, and the officers expressed their readiness to work with the Dai Association at the district level also. The Association meets the officers at regular intervals at the state level.
- UNICEF-Gujarat expressed willingness to support district level gatherings of Dais (Sept 2005).
- District level Dai Sammelans were organized during March–April 2006.

Efforts for enhancing capacities of Dais

- Capacity building of Dai trainers from 13 districts of Gujarat, India, was carried out on the basis of a comprehensive curriculum developed by the Dai Association (August 2005).
- Following this, the capacity enhancement training of Dais from Ahmedabad district of Gujarat has been initiated by the Dai Association, with financial support from the Department of Health and Family Welfare, Government of Gujarat (January 2006).
- A dialogue with the Department of Health and Family Welfare was held for recognition of Dai training by the seven founder members. The department has issued a directive to the District Health Officers regarding the same (November 2005).

Recommendations

Develop evidence on traditional midwifery

In the absence of appropriate local evidence, it is difficult to convince the scientific community about the importance of the Dai's role. There is a need for authentic research and evidence collection on the role of the Dai in childbirth.

Develop standards for traditional midwifery

While the tradition of home births by Dais operates informally, a need to develop midwifery standards for Dais is strongly felt. The National Institute of Health and Family welfare has been a pioneer in developing a curriculum for Dai training. Several NGOs have developed their own standards, curricula etc.

There is a need to review the existing efforts and, on the basis of the experiences, develop standards for traditional midwifery. The ISM and H (indigenous systems of medicine and homeopathy) department and Ayurvedic universities and institutions also need to be actively engaged in this process.

Enhance solidarity among existing Dais

At present, about six lakh Dais are working in isolation without any formal organization. There is a need to form Dai associations across regions. These associations can become platforms for building the capacities of Dais, regulating, standardizing and upgrading their professional skills and for advocacy.

Strengthen the Dais role in safe home births

The Dai tradition differs from place to place. Various training and follow-up efforts by NGOs have shown that through adequate training and follow-up, the Dais can become leaders of social change and can provide basic health services during pregnancy, childbirth and after childbirth as well as take care of the other socio-medical issues of women and adolescents.

The traditional role of the Dai needs to be expanded to include the health concerns of women and men as well as newborn care. Her acceptance in the community can be useful in allowing her to reach out to women in difficult situations, adolescent boys and girls and men in particular.

Ensure community support

While the Dai's role is critical for safe home births, because of her low status in the social class-caste order and her secondary status as a woman, she is often ill-treated and ignored by society. Being relegated to a secondary status, her own health is at times at stake. There is a need to support Dais in rural communities.

Public and private healthcare systems need to be sensitive to the social aspects of the Dai tradition and to recognize the fact that she is a member of the oppressed and disadvantaged section of society, which has been systematically marginalized. There is a need to provide community social support systems that will ensure social security and will create support groups and structures for the Dai.

Provide back-up services

It is evident in the existing scenario that unless Dais are involved it will not be possible to provide a trained person to attend normal deliveries. Hence, it is important that Dais are recognized and interwoven with the existing primary healthcare system and are actively involved in the PHC.

Trained Dais need to be supported by functional and effective public and private essential and emergency obstetric care services. Keeping the Dai as a central community service provider, special links need to be developed with the ANM, the Anganwadi worker (AWW) and the referral healthcare system.

Supervise the Dai's work

While Dais deftly manage home births, there is a need to supervise their work, particularly in remote, rural areas. This would enable monitoring of childbirth and correction of any discrepancies in the Dai's practice. In co-ordination with the AWW and the ANM, she should be made a part of this system.

Provide social security

Some of the measures that could be taken up to provide Dais with social security are given below:

- Making a local inventory of Dais and the women/men who want to take up this work
- Creating birthing homes for women
- Allocating land and resources for the cultivation of the herbs used by Dais
- Supporting Dais for referrals through training, support and supplies
- Displaying contact numbers and addresses of the doctors and referral centres as well as other related persons at a common community point
- Fixing up a standard remuneration system for Dais
- Providing Dais with social and health insurance

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