Traditional Birth Attendants

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IN India, with the establishment of Primary Health Centres and Sub-Centres, considerable progress has been achieved in the direction of making modern maternity services available in rural areas. However, a great proportion of births occurring in rural areas continue to be attended, assisted and managed by traditional birth attendants (TBAs). Traditional birth attendants, commonly known as 'Dais', have become an institution to render midwifery services in our rural areas.

The midwifery as practised by TBAs is influenced by their conviction in ther age-old ideas and procedures which are found to suffer from various defects and deficiencies. This in turn contributes to a large extent in exposing the mother and the new born child to the risk of different complaints and complications usually associated with pregnancy and childbirth. It seems essential as such to convert TBAs into a useful worker by weaning them away from their objectionable methods and practices. It will help in making available their services in rural areas which although not of high standard which modern health technology demands will yet be an improvement on what the vast majority of women in our country are now able to obtain. The Health Survey and Development Committee (1943-46) has observed:

"...She as the hereditary midwife has recognised place in the Indian home throughout the country and she therefore seems to be a valuable agent for spreading all over India the practice of modern midwifery, provided she can be made, by adequate training, to render reasonable efficient service to the mother and infant during the discharge of her functions. We realise that the dead weight of ancestral tradition may be so heavy on her that, in attempting to educate a woman of this type, the success achieved may prove to be quite limited. Nevertheless, we feel that, in view of the magnitude of the problem and by force of existing circumstances, the services of the traditional Dai, with such training as she can be made to assimilate, will have to be utilized over parts of the country for many years to come."

A need for such scheme to train Dais was felt in our country long ago. The modern maternity and child health services started in our country with efforts at training of indigenous Dais for practice of safer midwifery (Dutt, P. R.). The Government of India initiated the scheme for training of Dais during the Second Five Year Plan as a centrally sponsored scheme of MCH programme. During the Fourth Plan period the training of Dais was transferred to the Family Planning Department. In view of the importance of the role that these Dais can play in the field of MCH and Family Planning programme and for attracting a large number of Dais for training the scheme was reorganised during 1977—setting an ultimate objective of having at least one trained Dai in each of the 580000 villages in the country.

A review of the progress of the scheme of training of Dais in the country indicates that it has not met with desired success. A set of factors seem to be responsible for such a situation. An attitude of indifference towards training has been observed amongst large number of practising Dais who constitute the target group for the training. With her conservative outlook and lack of education she finds it difficult to believe that her traditional practice of midwifery is faulty and the new methods suggested by the health authorities are an improvement on her own. An essential component of the scheme should therefore be to secure her confidence and to win her over to adoption of certain necessary changes in her traditional practices without hurting her interests in the community. Such preliminary work is of utmost importance.

The Study

The study was conducted in the area under the Rural Health Training Centre, Najafgarh, New Delhi to know:

i. Socio-economic characteristics of TBAs practising in the area;

ii. Activities which are carried out by TBAs In rural areas; and

iii. To what extent TBAs trained by primary health centres are utilising training components to conduct safe deliveries in rural areas.

Fifty traditional birth attendants from fortyfive villages constituted the sample for the study. These TBAs were interviewed with the help of an interview schedule. In addition, detailed discussions were also held with maternity and child health workers who had long experience of working with TBAs in community with the objective to know their views and impressions of the mid-

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wifery practices of TBAs in their respective areas.

The Finding

Demographic and socio-economic characteristics of TBAs in the area are given below:

Age of TBAs: Majority of TBAs (74%) practising in the area were above the age of 50 years, 12 per cent were between 40-44 years and remaining 14 per cent reported their age as to be between 45-49 years. The average age of responding TBAs was 55.8 years.

Marital status: No unmarried woman was observed to be practising as TBA in the community. At the time of the study 62 per cent were widows and remaining 38 per cent were currently married women.

Literacy status: All the TBAs were illiterate without any formal educational base.

Caste: All the TBAs belonged to Scheduled Castes indicating that this work is usually confined in the hands of women belonging to a specific section of the community.

Source of income: Attending to functions related to childbirth was reported as to be the main source of their income. About half of the TBAs however informed that as their earnings from this work alone was not sufficient, in between, they have to seek other avenues of income and often function as casual labourers in the community.

Duration of stay in the area: All the TBAs were permanent residents of their respective villages and had a rural background. 92 per cent TBAs reported to have been born outside their present village of residence and settled in it after marriage. Remaining eight per cent were born in the same village where they were operating as TBAs. The period since when the TBAs were staying in their present villages is shown in Table I.

Table I.

Period since when the TBAs were staying in the present village.

Period	Percentage
Less than 30 yrs.	8.0
30-34 yrs.	12.0
35-39 "	12.0
40-44 "	50.0
45-49 "	18.0
Total	100.0

Traditional birth attendants reported of staying in the area of their operation for a considerable long period of time. 68 per cent informed that they were the residents of the present village for over 40 years, 24 per cent between 30-39 years and only eight per cent told of residing in the village for less than 30 years.

Reasons for Becoming TBAs

In the area under reference Dais who assist or manage this work in the community are placed on a low social status. As such this work usually falls on the shoulders of women belonging to socially and economically weaker sections of society. The factors that motivated the interviewees to become a TBA are shown in Table II.

Table II.

Reasons for becoming TBAs

Reasons	Percentage of Respondents
Family tradition	24.0
Family tradition and economical factors	62.0
Family tradition and hope for getting Government job	14.0
Total	100.0

A set of two factors consisting of family tradition and economic factors seems to have played a dominant role in interviewees' decision to become TBAs. Responding TBAs frequently mentioned of carrying out this work in the community. As from an early part of their lives they are exposed to this type of work in their families, it appears that they face little difficulty in accepting this responsibility when they are called upon to do so.

Family Members Practising Midwifery in the Community

The interviewees asked to state family members who were or had worked as TBA in the community from whom they had acquired this skill. On the basis of their replies it was learned that 24 per cent were trained by their mothers, 64 per cent by mothers-in-law and 12 per cent acquired this skill from their sisters-in-law.

Induction Process

From an early part of their lives respondents reported of having received exposure and orientation to this type of work in their families that enabled them to accept this work as a profession without facing any difficulty. As such it may not be wrong to say that the induction process starts from an early part of their lives though the time required to complete the process may vary from individual to individual. To begin with they start accompanying the established TBA to the homes of her clients so as to help her in carrying out various activities and to assist her in conducting child deliveries. Such occasions are utilized by an established TBA to transmit her knowledge to her assistant. By

such on-the-spot observation, guidance and participation, TBA-to-be acquires skills, knowledge and experience that is needed to carry out this work in the community. This type of 'apprenticeship' period showed a wide ranged variation and was reported to extend between 5 to 16 years. The respondents emphatically said "No" to a question as to whether they required such a long period to become proficient in their present work. It was added by them that as long as the established TBA from whom they have learned, continues to practise in the community, TBA-to-be prefers not to attend cases independently in the same area as it may cause clash of interest with the established TBA. It contributes to the long years of apprenticeship period.

Age at which Started Functioning as TBA

Age at which the respondents started functioning as TBA is shown in Table III.

Table III.

Age at which respondents started functioning as TBAs

Age	Percentage of respondents
Below 24 years	0.0
25-29 years	12.0
30-34 years	38.0
35-39 years	26.0
40-44 years	12.0
45+ years	12.0
Total	100.0

No interviewee reported to have started functioning as TBA before the age of 25 years. Majority of the respondents took up this work between the ages of 30-39 years. The average age at which the women in the area start functioning on TBA was found to be 35.8 years.

No woman stated to have started functioning as TBA before her marriage—74 per cent women had taken up this work during their married life and the remaining 26 per cent during widowhood period.

Training at Primary Health Centre

The realization of the objective to improve the skills of the TBAs is sought to be achieved by imparting orientation to them by the Rural Health Training Centre, Najafgarh at its three Primary Health Centres. The orientation training also aims at establishing meaningful collaboration between the Health Workers and TBAs so as to utilize their influence in the community for effective implementation of maternal and child health programmes. It may be indicated that tee training of TBAs in the area started in 1937-38 and it is generally agreed by the Health Workers of the area that it has positively contributed in checking complaints and complications in cases attended by such trained TBAs. The study observed that 76.0 per cent TBAs included in the scope of the study had attended and completed the training; the remaining 24.0 per cent were still untrained. Out of the TBAs who had attended training 36.0 per cent did so within three years of starting their work, 44.0 per cent between 3-12 years and 20.0 per cent after working for more than 12 years in the community.

The TBAs who had attended the training were asked to state as to why they had decided in favour of undergoing the training after working so long in the community. On the basis of their replies it was gathered that they did so much for reasons other than to improve or acquire safer techniques of conducting deliveries. For example, 42.0 per cent respondents were frank enough to admit that they accepted training as they were 'asked to do so' by MCH workers of the area, 48.0 per cent reported of doing so either to get 'official recognition and approval' or with the expectation that after the completion of the training they may be able to 'secure a government job' in the primary health centres. Only ten per cent informed deciding in favour of training with a view "to learn about and to improve their midwifery skills."

In the above background it may not be surprising to know that only about half of the TBAs who had attended the training were of the opinion that the training had proved beneficial to them, 12 per cent did not think so and remaining 38 per cent preferred not to express any opinion either in favour or against the training. In addition, majority of the TBAs who had completed the training did not feel the need of any further reorientation training. A large number of such TBAs seemed to be confident enough to handle "all types of cases" which they faced in their respective areas. It was also gathered that a large proportion of TBAs who still remained to be trained, fail to see the need and importance of orientation training. Majority of them (83.3 per cent) were not inclined to undergo the training and only 16.7 per cent untrained TBAs had expressed their willingness and interest for the training.

Midwifery Kit

To enable TBAs to conduct safe deliveries, each TBA on completion of her training is sup-

plied with a midwifery kit consisting of the following items:

Non-perishable items

i. Box with tray	one
ii. Meckintosh	one
iii. Douchcan with nazzle and tubing	one
iv. Bowls (10 cm)	Two
v. Soap dish (enamel)	one
vi. Nail brush (nylon)	one
vii. Dressing Scissors (blunt)	one
viii. Tea spoon	one
ix. Towels	Two

Perishable items

i. Soap cake (carbolic)	one
ii. Thread for cord	one ball
iii. Cottol wool	100 gms
iv. Dressing powder	50 gms
v. Dettol	
vi. Eye drops (locula)	

Table IV

Items of midwifery kit as available with trained TBAs and the conditions in which maintained

Items	% of TBAs with whom available	Condition		
		Good	Fair	Poor
Kit box	89.5	31.5	37.0	21.0
Scissor	81.6	29.0	40.0	12.6
Nail brush	68.4	31.5	21.4	15.5
Soap dish	71.0	37.0	26.1	7.9
Douchecan with nozzle & tubing	31.6	7.9	11.1	12.6
Towels	21.4	2.6	6.2	12.6
Tea spoon	18.4	5.3	7.8	5.3
Meckintosh	40.0	18.4	12.6	7.8
Soap cake	50.0			
Thread for cord	12.6			
Cotton	40,0	15.0	15.0	10.0
Dressing powder	65.3			
Dettol	18.4			

It was gathered that whereas perishable items are supplied only once with the kit to the trained TBAs, there is a provision to replenish perishable items of the kit by the Primary Health Centres/ Sub-Centres on a regular basis—once in a month.

It is expected of the trained TBA that she will maintain her kit in workable and hygienic condition and use its contents while conducting deliveries in her area. It was reported by all the trained TBAs that they had been supplied with midwifery kits. The kits as available with the trained TBAs were examined with the objectives to determine the availability of perishable and non-perishable items in the kits of the interviewees and also to ascertain the condition in which the kits were being maintained by the trained TBAs. The observations of the study are shown in Table IV.

It would be seen that at the time of interview no trained TBA was found to be in possession of all the items supplied to her in midwifery kit. If the use of scissors (to cut cord) and use of soap and nail brush are to be taken as sensitive indices of conducting safer and aseptic deliveries in rural areas, it would be observed that about one-fifth of the trained TBAs did not have scissors, around one third did not have nail brush and only about half of trained TBAs were found to be having soap in their midwifery kit. Those TBAs who did not have scissors in their kits reported of using shaving blades to cut cord. Of the TBAs who had scissors in their kit, 31.5 per cent were observed to be maintaining it in good condition and the condition of scissors as available with 58 per cent TBAs was found to be either fair or poor (broken etc.). Similarly nail brush as available with most of the TBAs was found in fair or poor conditions. The availability and conditions of the remaining items of the kit are shown in the table.

As per the revised scheme for the training of Dais, each Dai is entitled to a payment of Rs. 2 per delivery case conducted by her towards the cost of cotton, soap, antiseptic, drugs, etc. The payment of Rs. 2 is made only if the case is registered with ANM during antenatal period—if not, payment is allowed at the rate of Re. 1 per case only. It may be indicated that in the area under reference the local health authorities so far have not made arrangements for the above mentioned payment to the TBAs. In its place arrangements have been made to supply cotton, antiseptic, drugs, etc., to the TBAs through MCH section of Primary Health Centres. TBAs included in the scope of the study stated that they usually receive 'some' of these items from Primary Health Centres or sub-centres, majority of them adding that the quantity of the items supplied to them was not sufficient to meet their needs in the community. It was cited as one of the major factors by the trained TBAs for not having all the perishable items in their midwifery kit.

Services Rendered by TBAs in Rural Areas

Responding TBAs were requested to mention the services which they usually provide to pregnant women in their respective areas. The services as mentioned by trained and untrained TBAs are shown in Table V.

The table indicates that care, assistance and help during ante-natal period was rendered by about one-fourth of the total TBAs. Another area which was receiving less attention of the TBAs related to their role in imparting advice and guidance about personal hygiene and nutrition to the pregnant women. Further about one-fourth respondents were also observed to

Table V

Services provided by TBAs to pregnant women in the rural area

Services	% of responde. ts		
	Trained TBAs	Untrained TBAs	Total
Assistance and help during antenatal period	52.6	25.0	26.0
Assistance in labour & delivery	100.0	100.0	100.0
Postnatal visits/ massage, washing of clothes etc.	81.8	91.7	84.0
Referral services	50.0	25.0	44.0
Family planning	39.5	16.7	34.0
Personal hygiene and nutrition advice	10.5	—	8.0
Others (Treatment of sterility and other complaints)	18.4	41.7	24.0

be indulging in the curative aspects of various complaints and complications associated with pregnancy and childbirth. It was however encouraging to observe that a large number of TBAs besides conducting deliveries were also providing some type of post-natal care to their clients.

Compared in the background of their training status, it was gathered that comparatively a large number of trained TBAs were providing ante-natal, referreal and family planning services to their clients whereas larger number of untrained TBAs have stated to be providing care during post-natal period i.e., massage, washing of clothes and curative services.

Complaints and Complications Faced by TBAs

Following complaints and complications were reported by interviewees which they usually face in their cases:

While conducting cases: Twins; Breech; Excessive bleeding; Delayed labour; Irregular contraction; Extension of limbs; Obstructed labour; Shock.

Among new bornchild: Tetanus; Septic cord; Postules; Fever; Jaundice.

Faced with such situations, 24 per cent TBAs stated that they call health workers for on the spot guidance, 38 per cent TBAs reported that they try to handle such cases on their own and remaining 38.0 per cent respondents informed of referring such cases to primary health centres.

Impact of Training

One of the objectives of the study was to know whether the training programme as being carried out in the area for TBAs has made any impact in obtaining positive changes in the traditional practices of the respondents. It may be appropriate to indicate that the training programme lays down certain norms which the TBAs after completing the training are expected to observe in the area while providing their services to the village women during antenatal, intra-natal and post-natal periods. To what extent these expected activities are being carried out by the trained TBAs in comparison to untrained TBAs is shown on p. 120.

Summary

The study was conducted to know socio-economic characteristics of traditional birth attendants and activities that are usually carried out by this class of hereditary midwives in rural areas. The study further attempted to ascertain how far the TBAs who have undergone Dais' training at primary health centres are utilizing their training in conducting safe deliveries in their respective areas.

Majority of the TBAs (74 per cent) practising in the area were observed to be above the age of 50 years. They had started functioning as TBA at an average age of 35.8 years and their present average age was found to be 56.8 years. All of them were either currently married women or widows without any educational base and belonged to socially and economically weaker section of society. Attending to child births was their main source of income.

The respondents were inducted in this profession by their relatives who themselves were practising Dais. 76.0 per cent TBAs had also attended training programmes conducted by the Primary Health Centres. About half of such TBAs were of the opinion that this training has benefited them. All the TBAs who had undergone training admitted of having received midwifery kit from Primary Health Centres. The kits as available with TBAs were examined. Majority of the TBAs were observed not having all the items supplied to them in their kits and about one-fifth of the trained TBAs did not have scissors supplied to them which were reported either lost or broken. Further, the condition in which the kit and its contents were being maintained by the responding TBAs left much to be desired as most of the items were found in poor or fair conditions.

Activities that were carried out by TBAs in the community included intra-natal, some sort of ante-natal and post-natal care, massage, washing of cloth, referral services, family planning and treatment of sterility and other conditions. Comparatively a larger number of those TBAs who had undergone training at primary health centres were providing ante-natal, referral and family planning services whereas larger number of untrained TBAs had stated to be paying visits during post-natal period to wash cloth and for massage. Imparting advice and guidance to the

Performance of Expected Activities by Trained and Untrained TBAs

Period / Expected activities	Performance by respondents (In percentage) Trained TBAs	Untrained TBAs
Ante-natal period:		
i. She should contact every pregnant woman in her area and help her to register at the sub-centre or primary health centre	32.6	15.0
ii. She should attend ante-natal clinics and assist the sub-centre staff	10.5	2.0
iii. She should try to ensure that every pregnant woman in her area attends the ante-natal clinics regularly as per laid down norms	17.0	5.0
iv. She should try to ensure that every pregnant woman is immunized against tetanus	60.0	22.0
v. She should advise every pregnant woman to take nutritious diet and iron and folic acid tablets as prescribed.	15.0	6.0
vi. If an abnormal pregnancy is detected she should show the case immediately to the health worker/assistant or refer to sub-centre/primary health centre	25.0	15.0
Intra-natal and post-natal periods:		
When a TBA receives a call for delivery:		
i. She should take her kit with her	98.0	Not available
ii. She should watch the progress of labour carefully and she should allow labour to progress normally without any unnecessary interference	65.5 per cent of the total respondents informed of following the instruction. However remaining 37.5 per cent admitted of trying various devices/administering some sort of concoction for the purpose of speeding the progress of labour. Some such practices as reported by the TBAs included: making the woman to drink hot/warm water, administering the woman one tea spoon of ptycotis water (50 per cent). Applying mustard oil in vagina to facilitate the head easily. 12.5 per cent added that they send a call to 'private' doctor who comes and gives 'injection' so that the woman is able to deliver the child speedingly.	
iii. She should observe aseptic techniques while conducting the deliveries i.e.,		
a. by cutting nails	85.0	75.0
b. by washing hands with soap and water before conducting the delivery	85.0	25.0
c. By cleaning hands after washing with clean towel or clean cloth	40.0	15.0
d. Cut the cord with scissors/blades sterilized in boiling water	85.0	45.0
e. Sterilize the thread before typing the cord	55.0	generally use unsterilized thread
f. Clean baby's mouth with a sterilized piece of cotton	Most of the TBAs were using any handy piece of cloth for the purpose.	
g. She should see that her kit is always replenished, clean and ready for use during delivery	55.0	Not available
h. In difficult labour cases she should:		
i. Call health workers from primary health centres/sub-centres for guidance or refer the case to PHC	70.0	28.0
ii. In the post-natal period if she finds any complication in the mother i.e., fever or fowl lochia, or in the baby i.e., cord infection or jaundice, she should immediately inform the health worker or ask the parents to take the child to PHC	90.0	50.0
i. She should ensure that all the infants in her area are immunized with BCG, DPT and poliomyelitis vaccine	45.0	15.0
j. She should inform the deliveries conducted by her to health workers	The registration of births and deaths in the area is the responsibility of Municipal Corporation of Delhi. As such, the extent to which TBAs were assisting in the work could not be ascertained.	
k. She should assist in ensuring the registration of births in her area by reporting such events to the health workers of her area.		

(Continued on page 138)

Performance of Expected Activities by Trained and Untrained TBAs (Continued from page 120)

Expected activities	Performance by respondents (in percentage) Trained TBAs	Untrained TBAs
Family Planning:		
i. Spread the message of family planning to the couples of her area and educate them about the desirability of the small family norm	35.0	10.0
ii. She should motivate cases for the acceptance of F.P. methods	15.0	5.0
iii. Refer cases or accompany the motivated cases to the PHC/sub-centres for acceptance of D.P. methods—IUD insertions, sterilization	12.0	3.0
iv. She should act as depot. holder for distributing Nirodh in the community.	2.6	—
v. She should inform the community about MTP services as available in the area	2.6	—

pregnant woman about personal hygiene and nutrition was receiving very low priority from both trained and untrained TBAs.

Even faced with difficult situations majority of TBAs reported referring cases to primary health centres or calling health workers for on the spot guidance.

Studying the impact of training, it was observed that the training had made a definite positive impact in modifying some of their traditional practices. For example, 60.0 per cent trained TBAs were taking interest in advising their clients during ante-natal period to get immunization against tetanus and about one-third of such trained TBAs were helping women to register themselves with sub-centres or PHCs and to attend ante-natal clinics for check-up regularly.

Similarly, a larger number of trained TBAs were found to be following simple but significant rules of conducting safe deliveries i.e., to cut nails, wash hands with soap and water before conducting a case and to cut cord with scissor blade sterilized in boiling water. Even some of the TBAs who had not undergone the formal training at primary health centres were also found to have adopted some of these practices—possibly as a result of their contacts with the health workers of the area. It indicates that regular interaction between Health Workers and the hereditary class of midwife can play an important part not only in reinforcing the modified practices of the trained TBAs but also in introducing favourable changes in the practices of even TBAs who had so far not attended the formal training at Primary Health Centres. However, in the fitness of the situation it needs to be mentioned that satisfactory arrangements need to be developed to refill the contents of midwifery kit supplied to trained TBAs as in its absence trained TBAs are likely to revert back to their old objectionable methods and practices.

More trained TBAs were helping in spreading Family Planning message in the community than untrained TBAs. A little more than one-third of trained TBAs were observed to be participating in dissemination of information about family planning and twelve per cent were found to be referring cases of PHC/Sub-Centres for the acceptance of family planning methods. However, a few were found to be acting as depot. holders for distributing Nirodh in the community.