A National Consultation

On

The Role of Dais

In

National Rural Health Mission (NRHM)

1st and 2nd May 2008

A concept note

Context - The National Rural Health Mission (NRHM) is the largest government health programme in the country, seeking to bring life-saving services and preventive health education to our citizens in rural areas. Improving Maternal and Child health among the rural poor is among the key outcomes of NRHM. The NRHM envisages providing services through strengthening the public health system, making the process of decentralization more robust, and increasing the overall financial outlays. Recognising the current human resource constraints it not only proposes to include a variety of private providers within its ambit but also provides for developing a cadre of local women volunteers called ASHAs. However the emphasis on institutional delivery has not only ostracized the role of the Traditional Birth Attendants and Trained Birth Attendants (TBA - *dai*) in delivery but her role in any form of health care provision has been altogether ignored in this new policy paradigm. This abrupt shift does not recognize the thousands of birth attendants that were trained under various programmes, including those being supported by government agencies and international technical organizations even beyond the date of launch of the NRHM.

The NRHM is now nearly three years into its seven year life-span and it is appropriate to examine the consequences of this delegitimisation of the TBA-dai, and to enquire whether there are any valid roles for such community women leaders within such a comprehensive health care paradigm like the NRHM. A two day, two stage National Consultation on the Role of Dais in NRHM is being proposed on the 8th and 9th of April. This period is significant for a number of reasons because it is a period between the World Health Day, the National Safe Motherhood Day and the day on which NRHM was launched in 2005. A two stage process is proposed allowing for a day long meeting among experts, practitioners and key TBA leaders to discuss the current scenario and a half day interaction with key policy stakeholders. The details of the programme are described below.

Maternal and Child Health Care in NRHM – NRHM recognizes the importance of a local health volunteer as a key to ensure that appropriate and timely services reach the doorsteps of rural people. These women volunteers or ASHAs are not only supposed to supposed to generate demand for services but are also supposed to facilitate the delivery of maternal and child health services, including promoting institutional delivery and accompany women to hospitals. Thus, thousands of ASHAs have been trained or are in

the process of training. However grass-roots experiences have shown that the training process has been lagging behind the recruitment process in nearly all states.

According to current understanding availability of emergency obstetric care and adequate post natal care are the best insurance against maternal mortality. The NRHM service delivery paradigm promotes institutional delivery through the JSY incentivisation process. The reason for this is the view that institutional deliveries will ensure timely emergency obstetric services and ultimately the saving of women's lives. Various incentives, like those in the Janani Suraksha Yojana (JSY) and Gujarat state's Chiranjeevi Yojana, are designed to promote a greater number of institutional deliveries. While institutional deliveries have increased, and substantially in many places, there are also increasing reports of absence of appropriate facilities and very poor quality of care leading to life threatening complications for women. And even then in many of the NRHM high focus states home based delivery continue to be bulk. Thus provision for some level of home based delivery care remains a continuing concern.

With an overwhelming focus on delivery care (with the objective of reducing maternal mortality) there has been a lack of emphasis on continuum of care, especially in the post natal period which contributes to a significant number of maternal deaths. Experience and emerging evidence shows that in large parts of the country the discharge from institutions takes place well before it should be according to standard operating procedures.

TBAs and maternal and child health care –There have been differences in home based childbirth practices in different parts of India and there are various persons engaged in care during this process. This includes senior family members, persons with special skills in conducting home deliveries, persons who work as cord-cutters, masseurs and so on. TBA- dais have long been considered an important provider of childbirth and postnatal care services and are also known to provide services for the infant. According to the latest NFHS (Round 3 2005 – 06) findings an overwhelming proportion of childbirths, especially in the NRHM high-focus states took place at homes. Till a few years ago (and even after the NRHM had been introduced) hundreds of thousands of TBA – dais and even other village women were trained, re-trained, oriented to provide care during delivery. Even hospitals and nursing homes routinely employ TBA-dais to assist in the process of delivery.

The bulk of the emphasis of TBA training in the past was on '5 cleans', and this approach has now been found inadequate (especially since neo-natal tetanus has been controlled). This change in understanding of what constitutes appropriate healthcare intervention does not wish away the existence hundreds of thousands of women who have undergone training and have been providing services according to a norm which was acceptable scientifically till some time ago.

While the scientific '5 cleans' approach to childbirth has been found inadequate and has been discredited, there are a number of traditional childbirth practices which have been found to be 'scientific' after rigorous study. These include squatting or any other non supine posture for delivery, allowing the mother to walk and so on which were being

practiced by TBA-dais and are now being eroded due to ‘scientific’ training. Instead of ignoring their presence a more pragmatic approach will be to deliberate on their utility and incorporate them within the current framework and understanding of what constitutes quality care.

We need to recognize that TBA - dais are existing informal health workers of their villages, providing routine and sometimes emergency care and at a low cost at the doorsteps of village women. Instead of respecting their contribution, their time-tested skills and knowledge, and bringing new ideas and skills to them, there is an attempt to bypass them and render them redundant. Worse, they are blamed for the continuing high maternal mortality rates. The fact remains that emergency obstetric care is not available for large areas of our country, and that trained obstetrician-gynecologists and anesthetists are unwilling to serve in rural areas, resulting in maternal deaths. In this context, involving dais in NRHM would be important. After all, it is these doughty women of our villages who do the best that they can, despite the odds.

TBA and ASHA: role conflicts - Both the ASHA programme and the emphasis on institutional deliveries have had an impact on the dais and their traditional roles as the midwives of their villages. Ideally, dais should have been integrated into the NRHM, as they are most often deeply respected in their villages. In many cases they are considered leaders and even serve in the village panchayat. As a result they can be effective service providers and health educators. They can also help to monitor the progress of the NRHM, providing valuable first-hand feedback from the grass roots level.
In some areas of our states, dais have been selected as ASHAs. However, in others, this is not the case. In part, this is due to dais’ low literacy levels. It also may be due to the fact that ASHAs are appointed through connections and patronage of village leaders. And dais most often are poor, widows or single women, low caste and generally without the patronage of the opinion-makers in their villages.

This has led to conflict with ASHAs, as reported by several civil society organizations working with dais and others at the grass roots level. A potentially win-win situation of having dais as the ASHAs of their villages as a policy has been lost to some extent. If not recruited as ASHAs due to age or other factors, then at least involving an important village-based person like the dai and fostering collaboration between her and the ASHAs and the NRHM in general, would be beneficial all around.

Mobilising and Empowering TBA- dais - Many civil society organizations across various parts of India are engaged in enhancing capacities of TBA-dais in rural, remote and difficult areas. Many large government and internationally supported projects have contracted civil society organizations to support the TBA-dai interventions. In Gujarat
the Dai Association Gujarat has been initiated by Dais and Civil society organizations to work towards enhancing their visibility, capacities and advocacy for linkages in public health programmes. The Dai Association-Gujarat was launched in 2005, and supported by civil society organizations and the Department of Health and Family welfare, Government of Gujarat. Today about 8000 Dais and 18 NGO in the state of Gujarat are

associated with the Dai Sangathan. It has successfully organised two state level dai sammelans in recent years.

The grass-root level experiences of working shoulder-to shoulder with dais in Dai Sangathan Gujarat has shown that dais play an important role even today. This is so in both rural areas and urban slums. Not only do they provide life-saving services, but many are playing an important role in reaching other health services to people like immunisation, anti-TB drugs and health education. They can also monitor the NRHM at the village level, and can thus provide authentic information to strengthen this programme. Hence, it makes more sense to recognize them and integrate them in large programmes like the NRHM, to the advantage of all concerned.

Emerging Concerns - The discussion above highlights a few key factors about the role of TBA-dais in NRHM and these are

1. The NRHM has not made any provisions for the TBA –dai even though
   - Hundreds of thousands dais have been acknowledged and trained in this country
   - Home based delivery continues to be common, especially in the NRHM high focus states
   - Post natal care is important and institutions cannot and are not providing appropriate post natal care
   - Other informal and private health care givers have been incorporated into the paradigm

2. Operational confusions relating to community level care and support for maternal health
   - ASHAs are supposed to function as community based care givers and TBA- dais have been delegitimised as community based care givers.
   - Qualification criteria for ASHA limits the inclusion of TBA-dais as ASHAs
   - JSY incentives for facilitating service uptake is led to conflicts between ASHAs and TBA-dais at the community level

Possible Directions for the future – Considering the holistic and empowering nature of NRHM it is essential that these emerging concerns be addressed and a role be envisaged for the TBA-dai within the NRHM. Some of these could be as follows:

Efforts should be made to integrate the dais in the care of pregnant women. Their traditional role in child-birth can be expanded to include counseling for antenatal and postnatal services, immunization, family planning, health education, HIV/AIDS and TB control. In several states they are already providing such services. They can even serve to promote health insurance in the future, and ensure that insurance services actually reach the poor in their villages.

Second, we should examine the premise of the NRHM that institutional deliveries alone will reduce maternal mortality. If it is too early to study the impact of institutional deliveries on maternal mortality, then all efforts should be made to examine this at the

earliest. There is some emerging evidence to show that prescribing institutional deliveries for all women may not be the only or even best option.

National Consultation - Several organizations including Dai Sangathan Gujarat, Population Foundation of India and the Centre for Health and Social Justice are organizing a national consultation on the role of dais in the NRHM. The themes that will be discussed are:

i) TBAs as MCH care-givers.
ii) TBAs in childbirth—the continuity of care (home births and institutional care, referral care).
iii) TBAs in the spectrum of health care givers—i.e. their broader role as health service providers at the local level.

The Consultation will take place as a two stage process and take place over two days. On the first day NGOs and researchers, TBA-Dais and their organizations, from over ten states will discuss their experiences. Recommendations emerging from these deliberations will be shared with policymakers of the NRHM, as well as with donor agencies on the second day.