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Caste and the Cord-Cutters:

Traditional Midwives at the Crossroads of Social Stigma and Dwindling State Support

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Issue Brief

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ISSUE BRIEF

Caste and the Cord-Cutters:

Traditional Midwives at the Crossroads of Social Stigma and Dwindling State Support

| Avishi Gupta

ABSTRACT

This paper aims to situate dais or traditional midwives at the crossroads of caste-based discrimination and dwindling state support. A lot of traditional midwives or dais hail from a lower caste background which stigmatises their position and work in the society. With time, institutional healthcare facilities came to be associated with upper caste ideas of 'sanitation', 'purity', and 'cleanliness' quite synonymous with the colonial understanding of the same. Meanwhile, dais or traditional midwives were considered 'impure' 'untrained' and 'dangerous'.

The major focus of the article will be on the Indian policy towards midwifery and its neglect of dais. It will also explore how traditional midwives who opt for institutional midwife training often find themselves vulnerable to 'otherisation' since their traditional medical knowledge is constantly vetted against modern medical standards.

KEYWORDS: Dais, Midwifery, Health care, Rural women, Caste, Gender

INTRODUCTION

As the nation jostles with wave after wave of COVID-19, there has been an increase in scepticism towards institutional healthcare facilities amid the fear of virus transmission. This apprehension has particularly taken a toll on individuals who need regular access to pre and post-natal care. Between February and May, the second wave saw an increase in overall maternal mortality and stillbirths relative to 2020 (Srivastava, 2021). While COVID-19 infections in due course of pregnancy remain a significant cause for worry, disruption in access to maternal care remains a prime reason behind this rise in maternal mortality and stillbirths (ibid.). In such a scenario, it becomes essential to establish local and community-level networks of access to maternal care.

In the Indian context, these networks have existed for centuries in the form of maternal care provided by traditional midwives or dais. According to the guidelines on Ministry of Health and Family Welfare (2018), a midwife is recognised in terms of a nurse practitioner midwife - a designation earned after qualifying an array of training programmes and aptitude tests. However, often dismissed as mere "cord-cutters" (Jeffery et al., 2002), dais exist on the peripheries of institutionalised midwifery despite being crucial in delivering much-needed pre and post-natal care and assisting childbirths. The medical knowledge of the traditional midwives is not validated by or acquired through a government degree but is passed from one generation to the next through oral transmission among the women in the family and community (Shaikh-Lesko, 2014).

As per Indian law, only institutionally trained practitioners are recognised as midwives (Ministry of Health and Family Welfare, 2018) and constitute two cadres– Auxiliary Nurse Midwives [ANMs] and Nurse Practitioner Midwives [NPMs]. While ANMs function as bridges or first-contact persons between institutional healthcare and the community, NPMs are trained practitioners working in either hospitals or independently at the village level. The Government of India has made consistent efforts toward integrating traditional midwives within the folds of ANMs and NPMs. Still, the stigma associated with their practices and the ministry's rather top-down approach of 'modernising' the said practices often block channels for meaningful dialogue and integration.

This paper aims to critically examine these existing and potential roadblocks and assess the socio-economic position of dais in the present scenario.

HISTORICAL CONTEXT

The initial attempts at institutionalisation of childbirth, and by extension midwifery in India, can be traced back to colonial rule. First references to training programmes for traditional birth attendants date back to the 1860s (Jeffery et al., 2002). These colonial training programmes were driven by a reformist zeal and saw dais as "dirty and ignorant old hags" whose "unscientific" ways had contributed to rural maternal mortality (ibid.). Given the prejudiced colonial gaze, much of the orally transmitted knowledge of dais concerning childbirth and maternal care was either overlooked or, if recorded, was coloured with biases. These colonial lenses eventually ended up permeating the post-independence scientific thought in India.

The introduction of the Dufferin Fund hastened the initiation of rural midwives into colonial medical practice. Established by Lady Dufferin in 1885, the Fund aimed "to bring medical knowledge and medical relief to the women of India" (Dufferin 1885 as cited in Lal, 1994: 35). The Dufferin Fund promised to do three things primarily. First, create training programmes for women physicians, nurses, and midwives. Second, establish women's wards, thereby institutionalising women's healthcare. And finally, promote nursing and midwifery (ibid.).

The Dufferin Fund was followed by the creation of the Victoria Memorial Scholarships Fund in 1903. This fund exclusively aimed to restrict the practice of untrained birth attendants and train these women in 'modern' western childbirth practices (Guha, 2005) by claiming to offer regular stipends to dais throughout their training. However, the money failed to overcome the mutual distrust between the British male medical practitioners and the dais. There were instances of strong objection and discomfort from both the dais and the patients to male intervention during treatments and childbirth (ibid.). However, instead of initiating a meaningful dialogue, dais were vilified in the name of their "illiteracy" and "inability to comprehend alien ideas" (ibid.) whenever they expressed any form of unwillingness towards the involvement of male practitioners.

Besides the dismissive colonial gaze, the training programmes internally were also structured along caste lines. Throughout the 19th and early 20th centuries, caste hierarchies existed within the cadres of dais. In most middle and upper-class households, there existed two kinds of midwives. There were dais of a higher caste who were skilled in matters related to childbirth, and then there were dais of lower castes who mainly performed the tasks of cord-cutting and removing the placenta, tasks considered menial and polluting (ibid.).

Colonial training programmes were apprehensive of creating a 'homogenous' midwife cadre given the considerations listed in the Proclamation of 1858. The proclamation assured minimal to negligible Government interference in the religious matters of the people of British India. This meant that any attempt at overlooking caste considerations in training programmes for dais would mean violation of the clauses of the proclamation (ibid.). Therefore, these training programmes focused on training upper-caste dais.

The marginalisation of lower caste midwives was further accentuated by the British adoption of "aseptic cleanliness" motifs to promote western medicine in the subcontinent (Malhotra, 2003). In a subcontinent already saturated with ayurveda and the practice of hakims and vaids, the dominant upper-caste middle-class opinion could only be swayed in favour of western medicine by appealing to the notions of 'purity' and 'cleanliness' held by the upper caste groups (ibid.). Thus, in the context of childbirth, notions of 'dirt' and 'filth' came to be attached to the lower-caste dais, leading to their marginalisation. In the case of Punjab, this marginalisation was further imbued with a communal flavour. A large number of dais in the Punjab region were Muslim women belonging to the caste of fisherfolk, water-carriers, basket-makers, etc. Therefore, the notions of 'dirt' and 'impurity' commonly attributed to the lower-caste dais also accrued to the perception of Muslim dais (ibid.). These caste and religion-based discriminatory practices strengthened overtime, resulting in the creation of a women's cadre from marginalised communities engaged in much stigmatised and unremunerative village networks of midwifery as opposed to the cadre of institutionally trained, upper-caste, and upper-class midwives.

PLACING DAIS ALONG THE INTERSECTIONS OF CASTE AND GENDER

Presently, most practising dais belong to Dalit, Adivasi, and other socially marginalised groups and serve predominantly low-income and lower-caste households in villages and urban slums (Sadgopal, 2009). In many central and north Indian regions, the terminology used for a dai is indicative of her caste. For instance, in Madhya Pradesh, terms replete with caste connotations like khawaasin (naain), chamaarin, basodin, or mehtrin are used to refer to dais (ibid.).

A common misconception regarding dais is that their work is often clubbed under the umbrella of the traditional medical practice of ayurveda. By extension, many of the concerns regarding ayurveda also end up being associated with the practice of traditional birth attendants. While the practice of dais is not beyond criticism, this criticism should not fall prey to preconceived biases. Aside from receiving flack from outside the Ayurvedic community, dais also struggle with it internally. Ayurveda has continued to remain a traditional medical practice of largely upper-caste Hindu men (Jeffery et al., 2002). Obstetrics and maternal care have routinely escaped its purview since childbirth is commonly associated with 'shame' and 'pollution' (ibid.). As mentioned before, postpartum responsibilities such as cutting the umbilical cord, removing the placenta, washing the blood-soaked clothes, and bathing the baby are mostly taken up by the dais.

As mentioned earlier, there was a difference in the responsibilities of upper-caste and lower-caste dais in affluent houses. However, in many lower-caste and poor households which fell outside the social circles that practised ayurveda, lower-caste dais also assisted childbirth and provided pre and post-natal care. Thus, their knowledge and practice developed and passed on, regardless of ayurveda's influences.

However, the income of these traditional birth attendants remains meagre. Since their work is not recognised as a legitimate medical practice by the state, their remuneration from assisting each birth is completely subject to the whims of the employing household. Dais hardly get paid if the baby is stillborn or born with complications. The price paid upon the birth of a girl is much lower than that of a boy. Often, the compensation is solely determined by the degree of "happiness" caused by the birth (ibid.).

ADDRESSING DWINDLING STATE SUPPORT AND INADEQUACY OF TRAINING PROGRAMMES

According to the NFHS-4 published by International Institute for Population Sciences (2017), the percentage of births assisted by skilled assistance providers (doctors, auxiliary nurse midwives, nurses, midwives, and women health visitors) stood at 47% in 2005-06. A large chunk of the other 53% of births was assisted by traditional midwives. By 2016-17, the percentage of births assisted by skilled assistance providers had increased to 81% (ibid.) with dais assisting a mere 11% of total births (ibid.). The dwindling number of births assisted by traditional midwives is, among other factors, a result of the safe motherhood intervention scheme called Janani Suraksha Yojana [JSY]. JSY was launched in 2005 under the National Rural Health Mission. The scheme aimed to "[reduce] maternal and neonatal mortality by promoting institutional delivery among the poor pregnant women" (Ministry

of Health and Family Welfare, 2015). The scheme incentivised institutional births by promising monetary compensation for them.

Coupled with the increasing number of institutional births, the state-sponsored training programmes for ANMs, ASHA workers, and NPMs have also greatly reduced the role of dais in assisting births. This increase in the number of grassroot and institutional health workers in the field of obstetrics has merely put dais out of work and failed to integrate them into the expanding healthcare system.

In order to be assimilated into the healthcare system, a dai is required to undertake training and assessment from government or private institutions, for becoming an ANM or NPM. Most ANM training programmes, like their colonial predecessors, follow a top-down approach (Khan, 2021) and fail to initiate a meaningful dialogue with the dais and their existing practices. A meaningful dialogue here would involve communicating the need for substituting a traditional method with a more efficient one as well as assessing the scientific relevance of the traditional methods without dismissing them all as irrational.

A number of training programmes also embody a stark cultural contrast in terms of how they view a pregnant person. For instance, Saravanan et al. (2011) point out how training manuals and videos often end up treating a pregnant individual as a medical object or simply a patient. However, dais historically have had a more personal relationship with their patients in due course of assisting births. A dai treats a pregnant woman as her own daughter (Mukhopadhyay, 2011) and constantly caters to her need for support and encouragement throughout the process. This loss of personalised touch, which now follows strictly professional training, further deters dais from actively participating in training programmes.

In order to become an ANM, an individual is required to have completed their education up till the tenth grade and is also required to qualify for a few comprehension tests (Khan, 2021). This becomes an additional barrier for a large number of traditional birth attendants who are either illiterate or do not have the required educational qualification (ibid.).
The parameters for becoming an NPM are even more rigid. As per the 2018 guidelines on midwifery services in India, a candidate is required to have either a General Nursing and Midwifery diploma or a BSc Nursing degree from a recognised university and be registered as a practising nurse or midwife in order to be shortlisted for an NPM training programme (Ministry of Health and Family Welfare, 2018). Moreover, candidates are required to pass a series of tests, such as the Objective Structured Clinical Examination, an aptitude test, and an entry-level test concerning literacy and comprehension skills (ibid.).

Given that most dais face social and structural obstacles such as low literacy rate, lack of access to resources, caste, religion, and gender-based discrimination, even willing traditional birth attendants lose out on ANM and NPM training programmes to their more socially well-placed, upper-caste, urban or affluent counterparts. Moreover, there is only one national midwifery training institute and five regional institutes currently functional in the country (ibid.). Given their shortage, professional midwifery training is not accessible to dais working in geographically-disadvantaged locations.

DECONSTRUCTING THE MYTH OF THE UNCOOPERATIVE BIRTH ATTENDANT

As mentioned earlier, most state-led training programmes succumb to apprehensions regarding the practices of traditional birth attendants and stereotypical notions of them being rebellious and illiterate women. In such a case, a training programme is reduced to mere policing of what the state considers unscientific and untrained methods employed by dais. However, research has shown that many methods employed by dais are similar to those used in institutionalised medical practice. Moreover, dais play a key role in encouraging individuals to seek institutional care when necessary as well as creating community-level healthcare awareness.

As per Saravanan et al., (2011), even the untrained dais regularly followed the standard protocol of washing hands before the delivery, cleaning the instrument used for cord-cutting, advising the mothers to weigh their babies after birth, breastfeed, and bathe them. In such instances, formal training programmes only build upon an existing foundation. The programmes add new and more scientifically up-to-date perspectives on birthing positions, cord-cutting, breastfeeding, post-natal care, and other related topics to the dais' existing decades-worth of knowledge and experience. The understanding of the placenta as a part of the baby's body and the steps followed in its meticulous disposal inside institutional set-ups also find precedents in the practice of dais. According to the Jeeva Study (Sadgopal, 2013), which analysed the data on dais from Jharkhand, Karnataka, Maharashtra, and Himachal Pradesh, dais are often the first point of contact in remote locations. They are also giving primary preference in cases involving complications such as amniotic fluid leaks, breech babies, and delayed or retained placentas when hospitals are inaccessible. The study points out how these traditional birth attendants often managed to successfully deal with the complications without medical backup[1] as well as accompanied the pregnant individual to the hospital to provide moral support.

Besides assisting childbirth, dais play an important role in providing pre and post-natal care and augmenting community healthcare and awareness programmes. According to a study by the Barefoot College[2] (Azher, 2017) dais keep a close check on the dietary needs and life-style choices of individuals throughout their pregnancy along with their vaccination status. According to the same study, dais were also instrumental in spreading awareness regarding menstrual hygiene. While ASHA and ANM workers regularly conduct awareness and outreach programmes, rural women tend to trust the dais belonging to the village more readily than government healthcare workers. The findings suggest that dais were instrumental in persuading women involved in field labour to shift from menstrual cloth to more hygienic alternatives like menstrual pads. In cases where the village women were unable to afford pads, dais provided instructions for properly cleaning menstrual cloths.

[1] This argument does not challenge the need for training programmes. Instead, given that dais are the first point of contact in case of major complications, it emphasises the need for training them to handle these complications in cases of emergency.

[2] An NGO working in Rajasthan to train and organise awareness programmes for dais alongside studying their practices closely.

WAY FORWARD: GRASSROOT NGOs AND INCLUSIVE TRAINING MODELS

Many grassroot organisations like Matrika, Barefoot College, and Gujarat Dai Sangathan have been able to integrate dais in the formal healthcare network by initiating a healthy dialogue with them. For instance, Matrika followed a model where they asked the dais to train the researchers in their practice (Matrika, n.d.). They were thus able to glean important perspectives on pregnancy, childbirth, and pre and post-natal care shared by these women. Thorough knowledge of cultural roots of traditional birth attendants is necessary to structure comprehensive and inclusive training programmes. Besides training dais, it is essential to note that their methods constitute an important socio-historical and cultural asset that we are slowly losing in the face of the dwindling numbers of dais. This is a result of rapid institutionalisation of childbirth and an increase in the deployment of ANMs and NPMs. While upper-caste male-dominated traditional medical sciences like ayurveda have growing available literature, the oral knowledge of largely lower-caste and often illiterate dais is endangered. Thus, there is a need to document these practices from a cultural perspective. Matrika can again be used as an example in this context as they have managed to put together a database on methods and therapies used by dais (ibid.).

While dismantling a top-down approach towards training it is also essential to take note of caste inequalities prevalent within the cadres of dais. Thus, training programmes should also ensure adequate affirmative action to dais belonging to lower-caste backgrounds.

Moreover, the pandemic has severely limited access to institutional healthcare. In such a scenario, the role played by dais in terms of their micro-level presence and trustworthy and personalised care has become more crucial than ever. Dais attending to births during this time need state support more than ever, given that they mostly constitute an elderly population vulnerable to contracting the virus and lacking access to necessary resources like protective gear.

In conclusion, dais constitute an essential element in the healthcare network in the country, particularly the one catering to the marginalised sections of women who do not have easy or regular access to hospitals.

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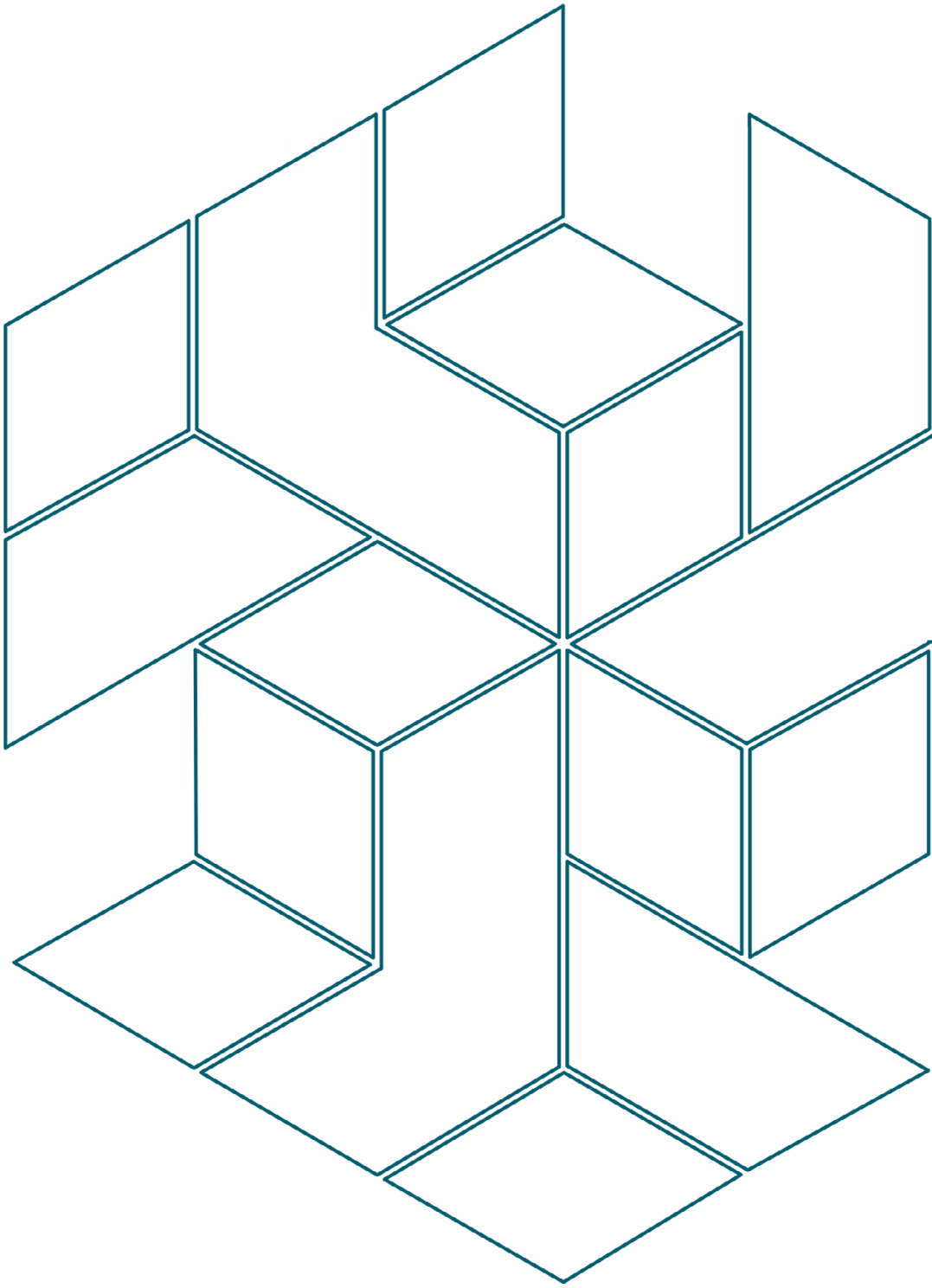

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