TRAINING OF TRADITIONAL BIRTH ATTENDENTS—SOME OBSERVATIONS

by

H. N. MATHUR*

T. P. JAIN**

and

V. APTE***

Midwifery services in India are far from satisfactory. Mostly it lies in the hands of traditional birth attendents (T.B.A.) who carry on this profession as family right. As early as 1946 Sir Joseph Bhore advocated the training of these local dais (T.B.A.) as an interim measure until an adequate number of midwives become available. There used to take place 10 million births in the British India and there were only 5000 qualified practicing midwives. Midwifery courses were given importance and priority but even after about 15 years, the state of affair did not improve (Mudaliar Committee, 1961). They noticed prejudice against the trained midwives and felt that it was not possible to replace the dai immediately. Mudaliar committee thus once again recommended continuation of dai training as temporary measure to overcome the problem. Another 17 years have passed since then yet even today Auxilliary Trained Midwife (A.N.M.)/population ratio is very low. Besides the shortage of A.N.M., even today in areas were A.N.Ms are available they have not been able to replace the local dais. How many more years would be required for replacement of these local dais?

Recently the Government has again realised that the local dai (T.B.A.) is indispensable for many years to come and have again reiterated Bhore Committee's recommendations of training of these dais. This programme appears to have been given much more importance this time than ever before. The staff of the Primary Health Centre (P.H.C.) i.e. the L.H.V. and A.N.M. have mainly been entrusted with the responsibility of training these dais in small groups of 8-10 through a 240 hours curriculum spread in 30 days. The course contents are inclusive of theory, practicals and demonstration on cases. The dais would be paid a stipend of Rs. 10 per day i.e. Rs. 300 for the entire course plus a kit bag. After the training the L.H.V. and A.N.M. are supposed to keep a tract of these dais to check and evaluate their performance. As a measure for this, dais would be paid Rs. 2 per delivery if the woman was registered for antenatal care and Re. 1 per delivery if the woman was not registered for antenatal care at some institution. It has further been envisaged that only one dai would be selected from each village of 1000 population.

*Senior Demonstrator, Deptt. of P.S.M.

**Prof. and Head, Deptt. of P.S.M.

***Ex-Professor of Gynaecology and Ex-Principal.

R.N.T. Medical College, Udaipur (India) 313 001.

Accepted for publication on 11-5-78.

Three training courses for (T.B.A.) under this scheme have been organised by P.S.M. Department of R.N.T. Medical College, Udaipur in rural areas. In our opinion the following facts need consideration.

1. *A.N.M. v/s T.B.A.*

The relations between the L.H.V., A.N.M. and the local dai are generally not very cordial. They regard each other as competitors. Local dai considers herself to know more than these young A.N.Ms and L.H.Vs. Therefore, in most instances they are not willing to be trained by the local A.N.Ms or L.H.Vs.

2. *Age Factor*

Dais generally are middle aged women, mostly married. Contrary to this A.N.M. and L.H.V. are generally young and in most instances unmarried. Obviously it may appear not to have any effect on dias accepting training from the ANM and LHV. Village folk and T.B.A. suspect the ability of these young, unmarried, inexperienced girls to conduct or even understand pregnancy and delivery. They believe that without undergoing the process one is not aware of the problems of childbearing. Therefore, the age and marital status also act as negative factors in their accepting training.

3. *Communication Gap*

Most of the A.N.M.'s and L.H.V.'s hail from Kerala or urban areas and are not conversant with local language. On the other hand, local dais being daughters of the same community, do not have language problem. No doubt, Kerala girls are able to grasp a little of local language, yet this is not sufficient to bridge the communication gap. Male nursing staff is generally from same district and can communicate better. It is, therefore, commonly observed that dais in need of help tend to fall more upon male nurse rather than ANM or LHV.

4. *A.N.M. and L.H.V. as Teacher*

The A.N.M. and L.H.V. are to play the role of a teacher in training the dais. The professional knowledge of most of the A.N.M.'s and L.H.V.'s beyond doubt has been found to be very poor and in most of the cases they are not competent enough (both in knowledge, practice and expression) to train the dais. Probably they themselves need training and retraining as very efficient teaching is required to train persons of low intellectual levels.

5. *Ego of the Dai, A.N.M. and L.H.V.*

All these three i.e. Dai on the one hand and A.N.M. and L.H.V. on the other. desire to show themselves to be superior. In community for various reasons the dais have been accepted superior to L.H.V. and A.N.M. Stipend of Rs. 300 may interest her and she may join the course but unless this LHV and ANM are able to generate healthy relations and better rapport; T.B.A. would not like to be supervised by A.N.M. or L.H.V. during her practice.

6. In the scheme of dai training it has been envisaged to enroll one dai from each village of about 1000 population (the one who conducts maximum deliveries, in case there are more than one dai in the village), and that in each training course about 8 to 10 dais would be enrolled. This poses the problem of collection of all dais for all days of training. Absentees are bound to be more since most of the dais have got some other domestic and agriculture work to perform and that trans-

port facilities in the rural areas are very poor.

7. The local dais who are mostly nai (Barber) by caste do not attend deliveries in certain lower castes e.g. harijan, schedule caste and backward tribes, and if some dai does it, she is out-casted. Hence representation of these lower caste in the roll of trainees even if more than one dai is to be selected from each village of 1000 population should also be taken into consideration.

8. *Antenatal clinics*

Antenatal clinics at most of the primary health centres and sub-centres exist only for namesake. If the work of the trained dai is to be supervised, checked and guided after the training, the antenatal clinics at the P.H.C.'s and sub-centres should be improved.

9. Certain obligations must be put on the trained dais.

(a) that they will get all pregnant women of their traditionally allotted houses registered in the antenatal clinics of PHC or sub-centres and would get all births and deaths of children registered.

(b) that they will refer all difficult and 'at risk' cases to the appropriate institution well in advance.

(c) That they would get all these cases immunised with tetanus toxoid in antenatal period.

(d) that they would attend delivery calls from all castes.

Since the understanding level of dais are limited they should be taught only the essential fundamentals in the beginning. More details can be given to them in subsequent refresher courses, provisions for which should be kept in mind. We have to impress on them that many obstetrical conditions are preventable if a woman has antenatal checkup. Though most of the women have normal delivery, there are a few cases where complications occur and we have to be extremely watchful during labour, recognise the complications early and advise the patient to go to a place where full facilities are available. It is our sacred duty to see that mother and baby are safe in our hands.

The following practical points should be impressed emphatically upon them:

1. Importance of previous obstetric history i.e. H/o. previous abortions, still-births, neonatal deaths, haemorrhage and operative delivery, etc.

2. Significance of age and parity.

3. Significance of stature of mother and big head of foetus.

4. Dangers of pre and post term delivery.

5. Significance of anaemia, oedema, jaundice and how to look for them.

6. Importance of antenatal care and explaining her specifically nutrition during pregnancy, personal hygiene in pregnancy (would also include exercise, smoking and alcohol consumption), immunisation during antenatal period, mothercraft, etc.

7. Palpation of abdomen for estimation of term. Significance of the small, big for term, transverse lie and excessive enlargement of abdomen (twins and hydramnios).

8. Duration of labour, the various phenomenon of labour, significance of labour, significance of prolonged labour and premature rupture of membranes.

9. Conduction of labour in clean surroundings:

(a) Washing hands with ample soap and water before vaginal examination is done.

(b) Care of the cutting instruments and ligatures.

(c) Not to do vaginal examination in A.P.H. cases.

(d) Not to repeat vaginal examination every now and then.

(e) To do vaginal examination at fixed intervals and the significance of various findings.

10. Complications of third stage of labour and to impress upon them the various causes of obstructed labour and warn them against use of oxytocic injections or use of barbaric methods like standing o abdomen or forcible ertraction or excessive fundal pressure or rotating grinding wheel on the abdomen. To teach them to look for perineal injury and its significance.

11. The dais should be motivated to explain and motivate the women and elderly women in the houses about family planning specially spacing. Generally after delivery the dai attends the case for about 40 days for massage to the women and the new born child. This time she can very well talk to the women informally about family planning.

12. *Teacher-Taught relationship*

Whosoever is the teacher, it should be kept in mind that they enjoy the community faith and for that they have their own ego which should never be hurt. Our approach towards them should be friendly, sympathetic and humorous. We should not forget that she works in most adverse conditions i.e. in dark ill-ventilated rooms with all unhygienic conditions and practices and that she is paid very little. The teaching should be more of discussion rather than lectures and it should be supported by extensive audio visual aid. It will not be enough to just give them a few lectures and let them off. The real worth of this training lies in continuous supervision and follow up so that in their actual practice they incorporate the teaching imparted to them.

Conclusion

Training of local dais (TBA) appears to be the only solution of improving our midwifery services at present. Various factors such as the relation between teacher and taught, age factor of the two, communication gap, teaching skill of the teacher, ego of TBA, selection of cases, representation of lower castes in the course need consideration. Besides this a wide and efficient network of antenatal clinics is a must for follow up and supervision which is of utmost importance. Informal discussion with extensive audio visual aids would make the teaching more effective and acceptable.

References

1. Govt. of India (1946): Report of the Health Survey and Development Committee, Govt. of India Press, Simla.
2. Govt. of India (1961): Report of the Health Survey and Planning Committee, Ministry of Health, New Delhi.
3. Letter No. 0. 13011/1/76-Ply. dated 2-3-77 of the Desk Officer, Govt. of India, Ministry of F.P. (Deptt. of F.P.), New Delhi.