AN INDEPTH STUDY OF THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN PROVIDING INTRANATAL CARE IN AN URBAN SLUM AND VILLAGES OF DELHI

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Summary

In an urban slum and four villages of Delhi 25 functioning Traditional Birth Attendants (TBAs) were interviewed, 35 deliveries conducted by them were observed and in 81 deliveries which could not be observed, a reliable attendant was questioned to study indepth the role of TBAs in providing intranatal care. It was found that majority of the women preferred home delivery by TBAs particularly in the slums since they were economical, accessible and helped in household chores. Only the TBA was found to possess a delivery kit. All except on TBA did pervaginum (P/V) examination with bare, unwashed hands, though findings were generally accurate. Majority conducted deliveries also without washing hands. Though 20(80%) TBAs said they preferred squatting position for conducting delivery commonest position observed was lying down, since, it was the practice in hospitals. Cord was tied, cut with a new razor blade and left without any dressing. Recognition and management of danger signals was unsatisfatory. In the slums indigenous practitioners were sought for management of prolonged labour leaking P/V and antepartum haemorrage, who injected syntocinon to hasten labour. Self-management of complications by TBAs consisted of abdominal manipulations to correct presentation, hasten delivery and manual removal of retained placenta.

Introduction

In developing countries like India, the advancing medical technology has created superspecialized hospitals. Although these institutions have antiseptic labour rooms equipped with the latest gadgets of modern technology they are out of the reach of majority of the mothers, who still prefer to be delivered at home by the Traditional Birth Attendant (TBA). An attempt is, therefore, made to study indepth the intranatal practices of the TBA who is an important health worker

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and an obstetrician to the majority.

Materials and Methods

The study area consisted of an urban slum-cum-resettlement colony called Janata Jeevan Camp and Ambedkar Nagar (Area I) and four neighbouring villages viz. Savitri Nagar, Begumpur, Shahpur Jatt and Khirki (Area II). Area I had only outpatient care provided by a DDA dispensary and mobile van of AIIMS. Area II had a MCH Centre with auxiliary nurse midwife (ANMS) for providing domiciliary intranatal care. The results in the two areas were however not found to be different and are presented jointly. Only when gross differences exist results have been presented separately.

Information regarding intranatal practices of TBAs was elicited in three different ways:

1. Direct interview of 25 functioning TBAs of the area on a prestructured and pretested proforma.

2. Direct observation of at least one delivery by each TBA by the investigator. 35 deliveries (at least 1 by each TBA) were observed and findings recorded.

3. Interview a reliable attendant other than the TBA within 24 hours of delivery in the remaining 81 deliveries conducted by TBAs.

All the findings were recorded on a prestructured and pretested proforma.

The study was carried out for a period of one year from November, 1984 to November, 1985.

This is a descriptive study, and hence no statistical methods are applied.

Results

As seen in Table I majority of the mothers in both areas preferred home delivery (86.36% in Area I) and (64.87% in Area II) but in Area I 84.54% chose TBA whereas in Area II 52.03% wanted a trained ANM who was available in that area to conduct their deliveries. However, in Area I the only trained Dai available was not preferred because she could not help in household chores.

The mothers who wanted TBAs to conduct their deliveries did so because the other family members could be looked after with the help of TBAs who helped in household work, because most families in the slum were nuclear (Table II)

Delivery kit was posessed by only one TBA. It contained scissors, small bowl, cotton gauze and dettol (when available), needle and silk thread.

TABLE - I
MOTHER'S PREFERENCE OF PLACE AND PERSON FOR DELIVERY

Area	Home delivery by				Health Centre		Hospital		Total	
	TBAs		Trained Dai							
	No.	%	No.	%	No.	%	No.	%	No.	%
I	93	84.54	2	1.82	—	—	15	13.64	110	100
II	19	12.84	77	52.02	32	21.62	20	13.51	148	100

TABLE - II
MOTHER'S REASONS FOR PREFERRING HOME DELIVERY BY TBA

	Reason	Area I (93)*		Area II (19)*	
		No.	%	No.	%
1.	Economical	40	43.01	—	—
2.	Home not neglected	46	49.46	10	52.63
3.	Easy availability	44	47.31	8	42.10
4.	Impersonal hospital	18	19.35	—	—
5.	Only primigravides need special care	3	3.23	4	21.05
6.	Previous safe experience	29	31.18	3	15.79

* Many mothers gave more than one answer

To clear the bowels and facilitate delivery, milk with ghee was given by 9(36%) TBAs to the woman in labour. Other things given were castor oil by 5(20%), soap suppository 3(12%), soap and water enema and herbal tea by 2(8%) each. Remaining 4(16%) gave nothing.

Management of first stage of labour was excellent. The TBAs generally stayed with the mother providing backrub and emotional support while encouraging her to walk about.

All the TBAs did pervaginum examination (P/V) but only one washed her hands before doing so. Repeated P/V examinations were done by only 7(28%) while 18(72%) specified that they performed the examination for the first time to see if os was open and of these 9(36%) said they repeated it if labour did not progress. This finding at direct interview of TBAs was confirmed on observation of deliveries conducted by them.

Full dilatation of the os was accurately determined by 19(76%) TBAs though none felt that this was the correct time for telling mothers to bear down. Observation of 35 deliveries conducted by TBAs revealed that in 4 cases mothers were made to bear down prematurely, resulting in edema of anterior lip of cervix. 20(80%) TBAs stated that on P/V examination if the head was higher than a bony projection (ischial spine) labour would take time and when it had come below this level labour would take a short time. Some TBAs even stated that if the presenting part is 1" higher labour will be over in 2 hours and so on. This corresponded well to our findings of the station of presenting part. This finding was obtained only by the first two methodologies.

As seen in Table III majority of the TBAs in both areas had neither the concept of nor did they practice hand washing before delivery. This finding is consistent by all three methodologies adopted to seek this information.

As seen in Table IV most commonly observed position during delivery was lying down. This was observed by the investigator and also reported by the attendants. On direct questioning however, majority of TBAs preferred squatting position and of late had started using supine position as hospitals and health centres used it.

TABLE - III
PRACTICE OF WASHING HANDS BEFORE CONDUCTING DELIVERY

As reported by	Washed with Water		Washed with Soap & Water		Not washed		Total	
	No.	%	No.	%	No.	%	No.	%
TBAs	1	4	6	24	18	72	25	100
Attendants in deliveries not observed	5	6.17	12	14.81	64	79.01	81	100
Investigator	3	8.57	4	11.42	28	80	35	100

TABLE - IV
POSITION OF MOTHER AT TIME OF DELIVERY

Position at the time of delivery	As Reported by TBAs		Attendants in deliveries not observed		Investigator (observed)	
	No.	%	No.	%	No.	%
Lying	12	48	42	51.85	21	60
Squatting	20	80	34	41.98	13	37.14
Others	—	—	5	6.17	1	2.85
Total	32*		81	100%	35	100%

* 7 TBAs used both lying and squatting positions.

New shaving razor blade was the commonest instrument used to cut the umbilical cord which was tied and left without any dressing in majority of cases. No TBA left cord untied and if an applicant was put on the stump it was ghee in the majority. The information was consistent by all three methodologies used to seek this.

Nine (36%) TBAs claimed never to have caused perineal tears. Of the rest management consisted of applying cotton swabs soaked in dettol or water, applying warm oil or ghee with thyme or turmeric or packing the vagina after application of alcohol on tears. This information was obtained by direct interview. Observation of deliveries conducted by TBAs also revealed that only 1st degree perineal tears were there and that too in only 9/116 (7.7%) deliveries conducted by TBAs.

Recognition and management of danger signals during labour was not satisfactory. This information was obtained only by direct interview. Most commonly recognised danger signals were obstructed labour and retained placenta followed by post partum haemorrage. Maximum references to hospitals/health centres were also in case of obstructed labour (Table V). For management of complications in Area II help of the ANMs was sought, though rarely, and in Area I indigenous practitioners were called frequently, specially in cases of prolonged labour, obstructed labour and post-par-

TABLE - V
RECOGNITION OF DANGER SIGNALS DURING PARTURITION AND THEIR MANAGEMENT

Sl. No.	Danger Signal	Recognition By (No. of TBAs) N = 25*	Management		
			By TBA herself	Indigenous Pvt. Practitioner/ ANM	Referral to hospital/ health centre
1.	Prolonged labour	21	12	7	10
2.	Obstructed labour	22	—	3	19
3.	Breech	16	9	2	5
4.	Other presentations	14	1	1	12
5.	Multiple pregnancy	6	2	1	3
6.	Post partum haemorrhage	22	9	7	6
7.	Retained placenta	23	18	4	1

* All TBAsrecognized more than 1 danger signal.

tum hemorrhage (PPH). These practitioners injected syntocinon 10 units I/M for prolonged and obstructed labour and metpergine for PPH.

TBAs management of complications was vigorous abdominal manipulations in prolonged labour and breech presentation, and massaging the uterus per abdomen while holding it with the other hand inside giving gur and some indigenous medicines in PPH (9 TBAs reported this). Retained placenta was managed by 9 TBAs removed it manually and 6 TBAs asked women to put their hair or dirty rags in mouth and say 'ooh'. This information was elicited on direct interview. Direct observation of deliveries revealed that in 29/35 deliveries vigorous abdominal manipulations were resorted to by TBAs to hasten labour, 28 of these were normal cases and one had APH.

Discussion

TBAs are playing a very important role in providing intranatal care particularly in the slum area, where their importance is due to the fact that they help in household chores in the nuclear family, are accessible and economical. Their intranatal practices, similar in the two areas, incorporated some which were beneficial, some harmless and others harmful.

The beneficial practices were: An excellent management of the first stage of labour, a practice reported also by D.N. Kakar (1980) use of a new razor blade by majority and not tearing the untied cord in any case. Use of new razor blade is a welcome trend since it is clean. Similar practice reported by Mathur et al (1983). Use of old blade has however been reported by Karan et al (1983) Tying of cord in all cases is also useful as Islam et al (1982) found higher incidence of tetanus neonatorum in those whose cords were left untied. Majority preferred squatting position because bearing down is easier. In modern obstetrics there is renewal of interest in this practice though TBAs have started following hospital practice of conducting delivery is supine position.

Harmful practices were : Indigenous practitioners called to give injection syntocinon in prolonged, obstructed labour or APH. Jafarey (1981) also reported similar

findings. Self management in cases of APH, leaking P/V and retention of placenta was done using dangerous techniques like abdominal manipulations and manual removal or useless ones like pressing midinguinal point in APH, giving spinach cooked in ghee for leaking P/V and giving the woman dirty rags or hair to chew and say 'ooh' in case of retained placenta.

TBAs being indispensable in the slums need to be given some elementary training like in the villages. An active collaboration of these grassroot workers with the existing health services would serve to strengthen MCH services in the fringe population of slums.

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