# Chraracteristics and Practices of Traditional Birth Attendants (Dais) A Preliminary Survey

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In our country, dais or traditional birth attendants (TBAs) play an extremely significant role in the care of mother and child.

In the rural areas, almost all deliveries are attended by dais. Even in our urban areas a good many births take place under their care. A pertinent illustration is the urban slum area of Mahmoodabad in Karachi, Pakistan's largest city. Here in an area just about two km away from the hospital resources of Jinnah Postgraduate Medical Centre, over 80% of the births took place at home and were attended to by dais-a situation shared to a large extent, by such other slum areas of Karachi as Orangi, New Karachi, Korangi etc.

Among these dai-attended urban births, casualties are not really as high as one might think-a point which does not alter the fact that most women received by hospitals in moribund conditions are those that have been attended to by dais at home-dais who refuse to believe that any problem is beyond their control. Unwilling to acknowledge defeat, afraid of being ridiculed or prosecuted, they desist from sending their patients to the hospital till the very last.

The result is that women reach hospitals dead or dying of such complications as a ruptured uterus, obstructed labour, severe haemorrhage, uterine inversion etc. The mishandling of dais may also show itself in the form of a high maternal morbidity like urinary and faecal fistulae and third degree tears. The foetus, too, suffers.

What, then is the solution? To pretend that dais do not exist or to hope that they will disappear, will not do. Evil as the dais may some times be, they are very necessary. Given our limited medical resources at the moment, especially in the rural areas, we need the dais and will continue to need them till we can expand and improve our existing maternity services.

What we can and must do is to recognize and accept the dais and give them the encouragement, guidance and basic training which will make them safer and move efficient and give them the courage and confidence to seek better qualified help when it is needed.

**A Preliminary Study**

As a preliminary to this objective, it was decided to study the characteristics and practices of dais within certain areas of Karachi, especially the area of Mahmoodabad, a slum area which is not only just two km away from Jinnah Postgraduate Medical Centre but which also has an ongoing maternity and child welfare project.

A special questionnaire was drawn up. Of the 23 dais that were interviewed, most came from Mahmoodabad with just a few coming from such other areas as Orangi and Malir.

It was difficult to get the dais to come to the Health Centre to be interviewed. Those who could not be persuaded to come to the centre by the Lady Health Visitors (L.H.Vs) were visited at their homes, their addresses having been provided by other dais. Once roped in, they were reluctant to talk sometimes even reluctant to admit they were dais. Reassurance, however, soon made them relax so much so that at times it become difficult to make them stop talking about the extent and good results of their practice.

**The Dais - Who they are**

Some of the facts which emerged from the interviews regarding the dais were:

1. That they lived in the same area where they conducted the deliveries and generally de livered patients of the same ethnic group e.g. Sindhi women were delivered by Sindhi dais, Pathans by Pathan dais and so on.
2. On an average, the dais were 46 years with an age-variation ranging from 30 to 80 years.

3. Of the 23 dais only one was single. Most had had children delivered at home by other dais or at hospitals.
4. Only six of them could read a little Urdu, and two could write a few words.
5. All, except two, had learnt their skills from their relatives mother, sister, aunt, mother-in- law etc. One was an 'ayah' (attendant) in a maternity centre where she had observed deliveries and one started on her own after watching relatives being delivered by dais. One of them had also attended a Gover-ment conducted dai training course without completing it, in Bannu in Northern Pakistan.

**What the Dais do**

The practices of the dais are very varied, with those within one area using similar methods. The salient practices that are commonly carried out by them are being described.

Antenatal Examinations: Generally there is no antenatal care. No examinations are carried out except an occasional abdominal palpition. This too, if the women complains of abdominal discomfort. If the baby is found to be 'low' it is pushed up by abdominal massage.

Blood pressure, weight, blood tests are not done, though some of them know that if the woman has headache or gross oedema she should be referred for a blood pressure check.

**Medication:** Only four dais said that they prescribed iron tablets if the patient complained of weakness, the rest gave no medication at all.

**Complications:** Malpresentations pose no problem for them. They feel quite confident about correcting them. For antepartum haemorrhage treatment is first given at home. The two conspicious methods are giving the women a drink of 'eenth' (brick) dissolved in water and injecting Pitocin to stop Weeding.

**Referral:** During the antenatal period, patients are referred to L.H.V.s, family physicians or hospitals for the following reasons:

(i). Extreme weakness
(ii) Gross oedema
(iii) Severe and persistent headache
(iv) Antepartum haemorrhage
(v) Suspected multiple pregnancy
(vi) Very young primigravida

**Labour:** Deliveries are conducted in the dorsal position on the 'charpai' (bed).

**Aseptic measures:** No aseptic precautions arc taken. One claimed to washing her hands only for delivery and one wore gloves (unsteri-lized). Few boiled the scissors used for cutting the cord. Oil was generally used for lubrication.

**Induction of Labour:** None thought there was a need to induce labour nor did they have the know-how to induce it.

**Potentiation of pains and expediting delivery:** for this there are various interesting variations. The most widely practiced method is to give a drink of hot milk with different ingredients in it listed below plus a few other method such as:

(i) Hot milk+Ghee (oil)+'soth' (dried ginger), Hot milk+eggs, hot milk +'alia' (small seeds of a plant) seeds or hot milk-choara (dried dates).
(ii) Eggs+'ghee' (oil) for 'suji halwa' (coarse ground wheat cooked with ghee and sugar.
(iii) A concoction of herbs.
(iv) Dhooni of 'Ajwain' (Anise-like seeds are burnt and their fumes allowed to pass over perineum).
(v) Inj. Pitocin' given themselves or calling in an L.H.V. or family physician to administer it.
(vi) Pulling out baby with hands if presenting part seen.
(vii) Dua (prayers).
(viii) Sending to hospital eventually.

**Post partum haemorrhage:** The beliefs and practices regarding P.P.H. are as follows:

(i) More bleeding 'good for patient' because it is dirty blood.

(ii) Raising foot of bed.
(iii) Giving a drink of'mako' (a small berry) or Bans (Bamboo) dissolved in water.
(iv) Administering Ergot Injection.
(v) Calling a doctor.

**Retained Placenta:** If the placenta is not expelled within half an hour or an hour the following methods are used:
(i) Finger or hair of patient is put in her mouth to produce retching which helps in expulsion.
(ii) A fair sized stone is put on the abdomen for pressure.
(Hi) The cord is pulled upon.
(iv) The hand is introduced in the uterus and placenta removed (manual removal).
(v) Patient is sent to hospital.
(vi) Perineal tears are not sutured.

**Postnatal care:** The patients are invariably visited for two weeks, sometimes upto 40 days.
At each visit, the patient's abdomen and the whole body is massaged and the baby bathed.

**Involution of Uterus:** To promote involution:
(i) Munaka' (Raisins) are given daily.
(ii) Abdominal binder is tied.

**Lactation:** Improvement of lactation is carried out by means of:
(i) Milk and 'Dalya' (local wheat porridge).
(ii) Ghutti' a concoction of herbs. (iii) Cooked goats intestines. (iv) Milk + 'zeera' (caraway seeds).

**For milk suppression:** Milk is expressed by hand or breast pump. The following ritual is also sometimes employed: A stick used to apply a local eye - cosmetic is passed over the breasts and then buried.

**Contraception:**
Quite a few of them are aware of different methods of contraception but few of them give advice. If a woman requests contraceptives, she is referred to a LHV, the family physician or hospital. I.U.C. Ds and pills are favourites with them.
The practices regarding the new born baby are as follows:

**Cutting of Cord:** The cord is cut with scissors after tying it with a string. It is cut late-usually after pulsation stops and sometimes after expulsion of the placenta.

**Bathing:** Immediate and then daily bathing of the baby is carried out by all dais.

**Dressing of Cord:** The cord is cared for in the following ways:
(i) Using nothing at all.
(ii) A dusting of talcum powder. (iii) Putting on antiseptic powder. (iv) Applying ghee (oil) when the cord is drying.

**Feedings:** They invariably encourage breast feeding but no milk feeds for the first three days are advised by most of them. For three days the baby is fed any of these:
(i) Chutti (a concoction of herbs).
(ii) Rose water and sugar.
(iii) Honey and water.
(iv) Ghee (oil)-a piece of cloth is soaked in oil and baby made to suck it.

**Resuscitation of baby:** Resuscitative measures are:
(i) Holding baby upside down by legs and slapping on back.
(ii) Blowing in ears.
(iii) Holding crushed onions to the nose.
(iv) Heating placenta (still attached to baby) on a pan.
(v) Heating of cord.
(vi) Splashing cold water on baby.
(vii) Mouth to mouth breathing.

**Maternal and Perinatal Morbidity and Mortality:** The question as to whether they lost any mothers or babies was a very sensitive one and information regarding it was witheld.
**Maternal Deaths:** Only two admitted to having had maternal death. One dai lost one patient and another, three patients. All the patients had died soon after delivery. Causes of deaths were:
(i) Post Partum haemorrhage.
(ii) Retained placenta.
(iii) Heart attack'.
(iv) Ghabrahat' (uneasiness) soon after delivery. There was no information on morbidity.
Perinatal deaths, stillbirths and early neonatal deaths were admitted to by four dais only. Greatest loss was due to breech deliveries and prematurity.
Convulsions among the new born were seen in five cases only.
Total Number of deliveries: The number of women delivered by each varied from a 'few' to 'thousands'.
**Remuneration:** the amount of money charged for service ranges from Rs. 50/- to Rs. 500/-according to the financial position of the patient. Generally the fee was between Rs. 100 to Rs. 200. In addition, the majority receive a 'jora' (suit of clothes) 'mithai' (sweetmeats)

## Discussion

The purpose of this study was to determine the nature of practices of dais in Karachi so as to help chalk-out a programme for their training.
The practices of dais may be either beneficial, harmless or positively harmful. In our survey too, we found some beneficial practices, like referral of very young primigravida, late cutting of the cord and encouragement of breast feeding, and few harmless-ones like giving raisins for promoting involution. But the large majority of the practices were definitely harmful. These include the lack of antenatal care, giving of oxytocic injection for A.P.H. and delay during labour, the lack of asepsis during delivery, the pulling on cord in the third stage, the careless attitude in P.P.H. that 'more bleeding is good' and methods of resuscitation of babies.
It is these dangerous practices that have to be guarded against. Training Programmes for dais should point out their mistakes to them and show them ways and means of applying safer methods. At the same time they should be commended for their beneficial practices. This will encourage them to seek advice when necessary. At present, it is found that they were more willing to seek the help and advice of LHVs rather than doctors, even if both are equally easily accessible. This reflects on the lack of communication between doctors and dais.
There is no doubt that dais are acceptable to a large majority of our women and will remain so for a long time. There is also no doubt that at present we need them.
It is therefore important that we, among the health personnel, develop a better understanding and appreciation of the role of dais in the obstetric practice in our country, and thus eventually help the woman and her infants.

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