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THE FEMALE CLIENT *and the* HEALTH-CARE PROVIDER

EDITED BY
Janet Hatcher Roberts and Carol Vlassoff

INTERNATIONAL DEVELOPMENT RESEARCH CENTRE

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Contents

Appendix

Dai and Midwives: The Renegotiation of the Status of Birth Attendants in Contemporary Bangladesh

Santi Rozario[1]

Introduction

World Health Organization (WHO) policy for some years has emphasized the use of traditional birth attendants (TBAs) as the best means of improving the appalling level of maternal and child mortality and illness in much of the Third World. Recently, however, some doubts as to the universal appropriateness of this strategy have begun to surface (Scheepers 1991; Stephens 1992).

My initial research on the question of childbirth and women's health (1991-92) was conducted in several villages in Rupganj (Dhaka district), an area where I had previously carried out research on women, development, and social change (Rozario 1992). In several forthcoming papers (Rozario in press; Rozario forthcoming) arising from this research, I discuss in detail the typical characteristics of childbirth in rural Bangladesh.

These characteristics include the low status attributed to, and the apparent lack of expertise of, traditional birth attendants (in Rupganj, these women are usually called *dai*), the lack of significant ante-natal or post-natal care for the mother, and the heavy emphasis placed on birth pollution and vulnerability to spirits (*bhut*). This pattern is essentially the same as that found by Banchet (1984, 1991) and Islam (1981, 1989) elsewhere in Bangladesh, and by researchers in much of rural India (Jeffery et al. 1988; Stephens 1992).

Childbirth among many other Third World societies, however, is a markedly different process. One could compare, for example, traditional midwives[2] among the Maya Indians of Central America (Paul and Paul 1975; Jordan 1980), in rural Jamaica (Kitzinger 1978), or, closer to Bangladesh, among Malay villagers (Laderman 1983). In each of these cases, traditional midwives are respected members of the community whose skills are generally valued and

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[2] I use the term "midwife," here as do the authors I am citing. As explained below, this term, with its implications of distinct group of women possessing a valued and specialized skill, seems inappropriate for most South Asian TBAs.

whose right to take charge of the care of the birthing woman is clearly recognized. In addition, their involvement with the birthing mother generally begins early in pregnancy and continues well after the actual birth. None of these things are true for traditional birth attendants in rural Bangladesh[3].

The "low status trap" in which most rural South Asian TBAs are caught limits the viability of the WHO strategy. In the present paper, I explore these issues further on the basis of recent fieldwork (1994-95) in a number of villages in Noakhali in Southern Bangladesh, said to be one of the more religiously conservative regions in the country[4]. In particular, I want to look at the way in which a small number of Christian-trained midwives seem able to avoid the "low status trap," and to ask whether there is potential for real change in rural Bangladeshi birthing practices.

Identifying the Traditional Birth Attendants

The most common term used to refer to TBAs in rural Bangladesh is *dai*. However, as Blanchet's (1984) and my findings (forthcoming, 1) show, *dai* is by no means the only term used to refer to TBAs. Terms such as *dhatri* and *dhoruni* (literally, one who catches the baby) are also used variously in different parts of the country. In Noakhali, I found that village women avoided using the term *dai*, but, although no specific term was used to refer to TBAs, they had no difficulty in identifying those local women who assisted at births. It is these women to whom I refer to in this paper as "TBAs," as distinct from the smaller number of trained "midwives," mostly associated with the mission clinic.

It is worth noting that the term *dai* is also commonly used in India, although the word itself appears to be of Arabic origin. In North India, the term is used to refer to women, generally of low-caste Hindu groups, but sometimes also Muslim, whose primary function appears to be dealing with and removing the "pollution" associated with birth (see Jeffery et al. 1988).

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[3] There are suggestions that the TBA's status is higher in parts of South India, at least among the marginal low-caste fishing population of the Mukkuvar (Ram, forthcoming and personal communication), and in Nepal, among the tribal Tharu of Dang (Krauskopff 1989: 159).

[4] My informants came from Hindu and Christian as well as Muslim backgrounds. However, my descriptions apply more directly to the Muslim majority than the Hindu and Christian minority groups except where I explicitly refer to Hindus or Christians.

The reason for the avoidance of the term *dai* is of interest. For Noakhali villagers, *dai* were a specific group of women who were historically called in especially to cut the umbilical cord. This is regarded as one of the most polluting aspects of birth, and would not be performed by anyone else.

There was a set fee in cash and kind for the *dai* who performed this task. Apparently, these *dai* no longer exist in Noakhali district, although some of the older community members do remember them[5]. The task of cutting the umbilical cord has consequently become problematic. Sometimes the birthing mother is made to cut the umbilical cord herself. On rare occasions, the TBA will do it provided she is appropriately paid for the task[6].

Women who assist at births in Noakhali today go out of their way to avoid being identified with the despised *dai*. Thus, most Muslim TBAs I interviewed told me without my asking, "I do not cut the cord." Similarly, when I enquired about the cutting of the cord, a Hindu woman who regularly assists at births told me that she will cut the cord only for her daughter but not for others. She said "if I cut the cord, will I not become a *dai*?" Her 20 year old daughter, who was present during the interview, said that the *dai* who used to cut the cord "are a separate *jat* [caste or sub-caste], there are no other *jat* below them."

The lack of a label given to TBAs in Noakhali[7] also indicates that these women do not see delivering babies as a viable profession. It is something they do when people need their assistance. It may also be an irregular source of material gain, but it certainly does not yield a regular or substantial income. For these reasons, I shall avoid the term *dai* in this paper, and refer to the women who assist at births simply as TBAs.

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5 Thus a trained Christian midwife in her early 50s told me that a *dai* was called to cut the umbilical cord when she was born. I was told on several occasions that babies might remain lying on the floor attached to the placenta for long periods of time until the *dai* arrived to cut the cord.

6 The payment is a real issue. Thus, trained Christian midwives such as the woman referred to in the previous note generally cut the umbilical cord themselves when attending a birth, but many families do not let them cut the cord since this is perceived to entail a separate expense.

7 They may call themselves *dhatri* if a label is needed. *Dhatri* is a literary term, which would be used to translate the English word midwife. Thus Shamima Islam (1989) notes that the term *dhatri* is used elsewhere in Bangladesh to refer to better-off and educated women who assist with birth only in few select houses.

Options for Birthing Mothers

Assistance with birthing is a problematic issues in the Noakhali region, as indeed it is elsewhere in Bangladesh. Because birth is considered to be extremely polluting, middle class families will generally employ a TBA to deliver the baby, clean up all the birthing substances, and bathe the baby before anyone in the family touches it. However, most rural families cannot afford to employ a TBA to perform these polluting tasks, and thus do not receive any assistance during birth from TBAs, trained midwives, or the hospital. At most they may be assisted by some family members (such as the mother, mother-in-law, sister-in-law, and so on). Sometimes a neighbour may be called in. The number of women who give birth entirely on their own in Noakhali, as elsewhere in rural Bangladesh, is thus significant[8].

When expert attention is needed (and can be afforded), rural families have two main options: (i) to call a TBA, who receive little or no payment, have low status and may have been involved in a limited training scheme, or (ii) to take the women to the government hospital or to a private clinic in the nearby town.

In some areas, including the Noakhali region, there is also a third option: to call one of the few properly trained midwives, most of whom are associated with a clinic run by the Catholic mission.

The Traditional Birth Attendants

The Question of Status and Payment

Although traditional birth attendants are readily resorted to by most middle class rural families, they themselves have very low status within village society. They are called at the onset of the labour pains, and are not looked to for medical advice. They merely come to "catch" the baby, or as the village women commonly use the term, to relieve (*khalas*) the birthing woman's travails by pulling the baby out. Although it is recognised that the TBAs have reasonable experience in assessing how the labour is progressing, which they do by inserting their left hands into the birthing woman's vagina, the elderly female guardians of

[8] Blanchet (1984), on the basis of her own findings and research by other health workers, suggests that village TBAs "do not attend more than a third of births in Bangladesh." She argues that the use of a TBA's services "has to do with maintaining social prestige or purity of caste and is only sometimes related to medical needs."

the birthing woman do not usually heed any advice the TBAs may provide. It is these guardians who decide, based on the TBA's assessment of labour progression, whether to bring *pani para* (blessed water), *chini para* (blessed sugar), homeopathic or allopathic drops to bring on the labour pains, whether to call a trained midwife, or whether to take the woman to the hospital.

When I asked the TBAs about how the villagers regard them, they each had stories to tell to illustrate the point that "*dhatris* do not even receive honour equivalent to half a paise [a small coin; 100 paise = US0.02c]." A typical comment was "when in danger they call you, but when the danger is over, get lost." Most of the TBAs linked the issue of status to the lack of any real recognition of their services in the form of payment.

They are usually given a bar of soap and a small bottle of *attar* (a special perfume used by Muslims before saying prayers), but neither money nor a sari (which is a standard gift in many parts of Bangladesh). The soap is given so that the TBA can purify herself thoroughly after delivering. The *attar* is given so that the TBA can use it before saying her prayers (*namaz*) for 45 days after the delivery. Some TBAs may receive a small amount of money, between Tk10 and Tk50 (US0.25c to $1.25). On the whole, however, they cannot expect to be paid as delivering babies is something they can do to gain spiritual benefit (*sowab*)[9]. It is said that the spiritual benefit from 101 deliveries is equivalent to a *haz* (pilgrimage to Mecca).

In fact, however, only a minority of the TBAs actually said that they do the job because of *sowab*. Even these, I suspect, said it because they felt it was the right thing to say, especially when speaking in front of other women. Most of the TBAs, on the other hand, vehemently complained about the lack of payment. At one Muslim delivery, several women were discussing how TBAs "should not take money because this is something done for *sowab*. If they take money for their service, then they cannot have any *sowab*." This statement was made in front of a Muslim TBA attending the birth, who did not reply directly. Rather, she made her point indirectly by saying "these days a *dhatri* [TBA] will not come unless she is paid Tk100.00 [about US$2.50]."[10] Another Muslim

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[9] The term *sowab* (Arabic *thawab*, reward, recompense) refers to the Quran, Sura 3, v.195: "I shall forgive them their sins and admit them to gardens watered by running streams as a reward" (David Waines, personal communication).

[10] When another woman joined her and said, "A trained *dhatri* will take a lot more", the TBA in question made sure that she was understood properly by saying, "No, a *dhatri* like me [i.e untrained] won't sit for any less than Tk100.00." Another Muslim TBA who

TBA, who was complaining about the rich being particularly stingy, told how one family, who lived in a brick house (which indicates considerable wealth) gave her a mere Tk10.00 note, in addition to the customary soap and *attar*, after she had attended a birth for one of its women. She said "I felt like pushing the baby back into the stomach."

Many other Muslim TBAs told me that they do not or cannot ask for any money, because people say "why do you ask for money, this is something you do for *sowab*." Hindu TBAs do not fare any better in terms of remuneration. Thus one Hindu TBA, Chenu Rani, told how a woman whose baby she delivered tried to dissuade her husband from giving her any payment by saying, "Has she touched me [*dhorey nai*] that you should pay her? Has she inserted her hand inside me?" The implication was that the TBA was paid only to compensate for the pollution, and that she had not been polluted enough to require payment. Chenu Rani's angry comment was, "Blood equivalent to a full water-pitcher [*kalash*] came out, and I delivered the baby, hasn't that any value?" She added "they call me non-stop when in danger, when danger is over they say *tumi amar ki bal falaichha* [a derisive village idiom implying 'what have you done for me']?"

There is clearly a conflict of interest here, but also a conflict of perspectives. Chenu Rani feels that she should be paid because she delivered the baby, but the mother argues that she should not be paid because she did not have to insert her hand inside her or deal with other specifically polluting aspects of the birth. The implication that the TBA is paid to compensate for the pollution is also present in relation to the conflict over cord-cutting. Most TBAs say they do not cut the cord, which is the most polluting task of all, because they would not be paid the large amount associated with doing so.

There is no doubt that most TBAs attend births in expectation of some form of payment. My understanding is that, even though they generally say that they are not paid at all, they are in fact paid by at least some families. It is clear that these women are in a bind. They need the money, and once a woman becomes acknowledged as an experienced TBA, she usually must be ready and willing to assist a family in delivering if called, because as everyone says in the village "this is the job of *sowab*." Yet, it is only in time of need that village society is prepared to recognise their value. Beyond the *oshot* [evil] and *oshouch* [polluted] *ghar* [hut, room] where birth takes place, these women have no value.

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lived in another district for some years before moving back to Noakhali said, "In Noakhali, *dhatris* are worth nothing. In Jessore, my suitcase would fill up with saris."

The rhetoric of gaining *sowab* from delivering babies and the common practice of handing out of soap and *attar* to poor TBAs after they attend births but not actually paying them for their services are linked by a simple logic. The rhetoric of *sowab* prevents TBAs from demanding or even expecting any renumeration; at the same time it justifies the use of their services without payment by the more well-off section of the village society. But every family at least hands out soap and *attar*, and so reinforces the notion that the TBAs should do deliveries for *sowab* and not for money.

Problems with TBA-Assisted Births

The medical problems associated with TBA-assisted births can mostly be understood in terms of their low status and marginal position in the birth process.

- No ante-natal care is provided by the TBAs nor is it expected of them. The TBA's involvement begins when she arrives for the delivery and ends as soon as the birth is completed.
- At least 90% of the TBAs I interviewed said they do not wash their hands before delivery. When I asked whether they are given soap and water to wash hands before the delivery, they were usually very surprised at my question. Several responded by asking in turn, "Why soap and water before? It is after the delivery that we need to clean ourselves."
- There are usually too many women and children crowding inside the delivery room. Some TBAs complained that it may be difficult to concentrate because too many people are saying too many different things, making the TBA or the birthing woman confused and worried. Yet it is not the TBA's place to decide who comes in and who does not. The common feeling among Muslims is that the presence of many adult women means more courage and more ideas. Also, "who knows with whom the *feresta* [angel or guardian spirit] will enter the delivery room?" The *feresta* comes to help relieve the woman's suffering [*khalas kara*].[11] Thus a Muslim woman whom I came to know very well, said "people

[11] This term *khalas kora* [to relieve, to deliver of a burden or a difficulty] is used commonly to refer to the actual moment of the baby's delivery, until which the birthing mother is perceived to be in danger. The TBA may also be referred to as relieving [*khalas kora*] the birthing woman. Revealingly, TBAs said to me that they were treated well by their clients and made very welcome until the mother had been "relieved" by them but after that they are nobody to the client's family.

sometimes say when 'luck has opened up [becomes favourable], the mother has been relieved quickly because a particular woman has entered the delivery hut."

- The TBAs are unable to examine the birthing woman properly. TBAs will not uncover a birthing woman to see the vaginal area as it is considered most polluted and shameful. One woman said "There is a big *dabi* [demand for money] if a *dhatri* sees it [the vagina]". She added "it is *gunah* [sinful]". It is not good for the *dhatri* or for the birthing woman to see the vagina, and it may be harmful.[12] Due to the polluting nature of birth, TBAs use their left hand to assess how labour is progressing and use the right hand only at the last moment to draw the baby out.[13]
- The cutting and tying of the cord generally takes place under unhygienic conditions. Many said a bamboo slip is used for cutting of umbilical cord, saying it is better than a metal blade. At one birth I attended, a bamboo slip was used and the family did not seem to have a blade anywhere. The thread used was not boiled. The TBAs also smear ash on the navel area of the baby. This is believed to help the area to heal after cutting the cord. As explained previously, the cutting of the umbilical cord, which is seen to be most polluting of all the tasks associated with birth, is in any case not necessarily done by the TBA. Often it is done by the birthing woman herself or by her mother or mother-in-law in order to avoid the large payment associated with this task.

TBA Training Schemes

A few of the TBAs are now receiving training by various government and non-government organisations. In addition to the government's training programme, almost all of the NGOs working in the area of family planning in the Noakhali region offer similar training to existing TBAs.

The training involves two or three short courses, each lasting for several days. These are followed by refresher courses for one day each month for 36 months. The training involves giving the TBAs some lectures and information,

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[12] *Eta dhekley bachhar khoti, dhatriro khoti.* "If you see it, it is harmful for the baby, it is harmful for the dhatri too."

[13] Many TBAs made comments to me about how bad they felt about the smell of birth, how they were unable to have food after deliveries, had to have several baths to clean themselves etc.

sometimes with pictorial booklets, on cleanliness (i.e. the importance of washing hands before delivery and the need to boil the blade and the thread), the need for the TBAs to cut the cord, the need to refer women to Family Welfare Visitors, trained midwives or the hospital when they perceive difficulty, and other such issues.

There are no practical components to the training. It is generally believed that the TBAs know how to deliver, and that they need training only about hygiene and how to refer cases to the hospital when they cannot deal with the case. They are usually given delivery kits. This delivery kit plays an ambiguous role in the TBA's career. If a TBA carries a delivery kit with her to a birth, she may be considered as trained; in other words, the delivery kit is a symbol of training and status.[14] Yet in many instances a trained TBA will not carry her delivery kit to a birth because "people [will] make fun of me." Another consideration is that if a TBA carries a kit, people may assume that she is paid by the government and fail to give her even the minimal payment she might otherwise receive.

It is worth considering what type of women attend these training courses. I went to a refresher course session attended by some thirteen TBAs on a government scheme. Most of the women were in their early 30s, and only three were over 40 years old. Most of them had small children. Two of the women had four or five years of education, while the rest could only write their names. It was clear to me that they were all very poor and desperate for a job. A few had never delivered a baby before their training. Three of the women were widows, one's husband "had become mad," and three women had two or three co-wives and were therefore not looked after by their husbands. One woman's husband had a tea stall, five women's husbands are rickshaw-pullers. The women were paid Tk40 (US$1) per day to attend the course, which seemed to be an inducement in itself.

The TBAs do gain some awareness about hygiene and other matters from their training, which no doubt slightly improves the kind of services they can provide the village women. However, their ability to insist on using the ideas and knowledge they have gained from their training in an actual situation remained very weak. The amazement of the women at the training session when I sat next to them on a bench brought home to me anew the significance of the

[14] For instance, with reference to a Muslim TBA (Halima), who was trained through a government scheme of the kind described above, I was told by a Christian female informant, "Halima is not trained, because she does not carry a delivery kit".

rigid status hierarchy in Bangladesh and South Asia in general.[15] Society at large does not accord these women any status or honour. Nor do the village people with whom they have to deal with on a day to day basis. The rural society's image of these TBAs as poor, illiterate, women without suitable male guardians, and therefore of lowly status, undoubtedly has a detrimental effect on them. The situation is not helped when TBAs are only given minimal training, and not paid a proper salary by either the government or the people they assist. These minimal training programmes can have little impact by themselves on the traditional birthing practices of the village. The village people must value the TBAs' opinion and judgement; this, however, will not happen because of their poverty and the low status attributed to these women. At present, they are laughed at should they suggest new ideas or even bring their delivery kits. This "low status trap" in which the TBAs are caught is the central problem with TBA-assisted births in the village.

The Hospital

The local government hospital in Noakhali was built during the period of Pakistani rule, but inaugurated in the early 1970s. While it apparently had a good name in its early years, its reputation now is very poor. Many of the TBAs told me stories of their experiences when they accompanied a complicated delivery case to the government hospital. Not a single person - TBA, trained midwife, or any of the village people in general - had anything positive to say about the place. People referred to it as the "slaughterhouse". No-one wanted to take their birthing women there unless it was absolutely unavoidable.

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[15] Status hierarchy is rigidly maintained at the training centre. I was offered a chair to sit next to the Family Welfare Visitor when I arrived. But afterwards when some of the trainee TBAs left, there was some room on the bench next to other trainee TBAs. So I sat there to chat with the women more informally after their training session was over. The women seemed most impressed that I should consider sitting next to them on the same bench. One woman said "No-one ever sits like this with us, the way you are mixing with us, it never happens with us." Blanchet (1984:149) also notes that, in the S.C.F. project, upper-class women, those who sometimes assisted in the delivery within their extended families and the immediate neighbourhood but did not accept any payment, refused to sit "on the same benches as poor, low-class *dais*, and for a long time they refused to attend any training session unless it were carried exclusively for them."

I visited the delivery section[16] od the government hospital on several occasions. What I saw was simply horrific. It is overcrowded, mattresses are placed directly on the floor, the ward is littered with old bandages.

Only a very small minority of women are taken to the hospital before a TBA or and/or a trained midwife has been tried at home. The vast majority arrive when the TBA (or the trained midwife) decide they cannot handle the birth at home.[17] Problems with the hospital centre around the expense involved in making use of it, and the mistreatment and lack of treatment of patients.

Expenses Associated With Using the Hospital

The government hospital is supposed to be free for the patients: bed, services, food, and medicine are all supposed to be provided without charge. In reality, the case is otherwise. I have numerous stories of people telling me how much it cost them when they took their birthing women or other patients to the hospital. A trained midwife told me "it is as if every brick of that hospital building opens its mouth for money." The cumulative costs incurred from entering a hospital and being treated by doctors and nurses are very high in village terms. Some of these costs, none official, are: the entrance fee to the hospital, medicine, charge for doctor, charge for nurses, and charge for *ayah*. To this must be added food for relatives staying with patients 24 hours a day (up to three per patient are necessary since the hospital itself provides no services), travel back and forth to the hospital by relatives, and so on.

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[16] i.e., the women's section in general - there is only one ward for women, so that obstetric cases are placed in the same ward as all other cases. Of the present 150 beds in this government hospital, only 30 beds are set aside for women. The rest of the hospital is for men. Beside the 25 beds in the main ward, there are a few beds in separate rooms which women's families can use if they pay for them. Apparently there is talk of increasing bed numbers by 100, but no one knows whether this is a realistic expectation.

[17] TBAs are often accused of waiting too long before referring the patient to the hospital, or of using homeopathic or allopathic drops to bring on the labour pains prematurely, leading to severe tearing of the uterus or other complications. Such comments about the TBAs are made by hospital staff (nurses and doctors) as well as by the trained midwives based at the village level, who are often called by village families when a TBA cannot handle a birth. Ivy, the midwife based at the missionary clinic in Noakhali, told me of several instances of her attending birth after a TBA had been called, or after a birthing woman had been in labour for two or three days, resulting in all kinds of complications.

Entrance fee

A family may arrive at the hospital at any time with a serious delivery case. They will not be allowed to pass the main gate of the hospital building unless an entrance fee is paid. As this entrance fee is not official, the guard charges whatever he thinks fit from clients, from Tk5 to 50 [US12c to $1.25].

Medicine

A major cost that no one can avoid is that for medicine. Patients are given prescriptions and their guardians are expected to go to one of the numerous pharmacies immediately outside the hospital gate to get the medicine at their own cost. Many villagers commented that the pharmacies are owned and run by the hospital doctors, and that the medicine on their shelves usually comes from the hospital stock (which is supposed to be distributed freely to the patients). While I have no evidence to support these statements, it was interesting that when I took some photographs of these pharmacies I was confronted by a shopkeeper who enquired whether I was a journalist and asked why I was taking photos. His suspicion about me made me think there may very well be some truth in what village people say.

Doctor's, Nurses' and Ayah's charges

If the delivery entails a Caesarian or other surgical procedure, the doctor apparently makes a contract with the birthing woman's family as to the amount he would be paid - the amount can vary from Tk4000.00 to Tk12,000 (US100 to 300). Again I do not have any evidence to prove what village people told me, but such statements were made by numerous people, including TBAs and trained midwives, as well as village people, which makes me think that there is some truth in the rumour.

Even when a straightforward delivery does not entail a direct charge for the doctor, there are various other costs. The doctor does not usually handle normal deliveries; these are handled by the ward nurses who are fully-trained, including a year of midwifery. A certain amount has to be paid to the nurses who attend the delivery and mind the ward. In addition, payment has to be made to the *ayah* who is supposed to do the general cleaning after the delivery, as well as washing the birthing woman's clothes and changing the sanitary pads. She will

not lift a finger until she has been paid in advance for each of these tasks.[18] When I asked the birthing women's female relatives, they did not know exactly how much was being paid, but they knew that something would be paid to the nurses and the doctor, including providing several morning and afternoon teas (with snacks of savouries and sweets).

Travel

The costs for village people also include trips back and forth from their home to the hospital on a daily basis. Since no services are provided by the hospital staff except for the actual delivery, every patient needs at least two to three people to attend her all the time. These relatives have to buy their own food from the food stalls outside, which can cost quite a lot of money, especially in cases when a patient needs to remain at the hospital for a long period of time.

Mistreatment of and Lack of Treatment for Patients by Hospital Staff

Here I summarize my observations from my first day at the hospital, which proved, from subsequent visits and from the numerous stories I heard from patients, to be quite typical. I arrived at the women's ward at 9:30 am and found a woman, who was brought into the hospital about midnight and had a forcep delivery. She was half-sitting on a bed on the floor and looking lost. She had her mother with her. They were wondering what they should do with the baby, whether to feed it or not. At home, they normally would have used some honey or mustard oil, neither of which they had with them. The two women were feeling quite lost, and were waiting for the birthing woman's father to arrive with some mustard oil. They were scared to ask the nurse for anything.

The birthing woman was in pain and needed to go to the toilet. She was wondering whether she should get up to walk to the public toilet. I volunteered to ask the nurse in charge whether it was OK for the woman to go to the toilet.

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[18] The sister of a birthing woman told me that she got tired of having to pay Tk50.00 (US$1.25) to the *ayah* each time a little job had to be done for her sister. So she started to do everything, including changing her sister's pads. I witnessed an argument between an *ayah* and the father of a birthing woman about the amount she should be paid for cleaning up after the delivery. She refused to accept Tk30, or even 40, saying "ask the doctor". Later she added, "what will the doctor say?" Such statements from *ayah* imply that everybody knows that they charge fees, and more importantly perhaps, it suggests that they may actually have to divide up their earnings with the nurses and maybe the ward doctor. The amount paid to the nurses is not set and varies from family to family.

The nurse said yes. After the woman's mother and I helped her to walk to the toilet she nearly fainted on the toilet seat. She needed to be changed, including her sanitary pads, but no-one was there to help her, so I helped her. Then I went to the nurse again to ask for a bed-pan. She told the *ayah* to give us one. Without prompting, the birthing woman and her mother started to complain how rude the nurses were, how they refused to talk to them, and so on. I again went to ask the nurse what is to be done with the baby. The first time she ignored me. I asked again and then she turned around to the new mother and said she should feed the baby, "it is their fault, why come so late to the hospital, we had to use forceps; of course it will be difficult for the baby."

Then the doctor came to do his rounds - it took him about 10 to 12 minutes, no more, to go around 26 patients. His rounds consisted of merely making a hand gesture to the attending nurse with a few words like "discharge this one", or "let her be for another day", or taking an old bandage off Caesarian patients and putting on a new one, throwing the old one on the floor. There was hardly any interaction with the patients. Sometimes patients would call to him as he turned away, but he simply continued to the next patient. A few patients I spoke to before the doctor arrived had many questions they wanted to ask the doctor, but they could not. The women were overwhelmed, clearly feeling out of place.[19] I was told that if a patient's guardians pay a large sum of money to the doctor and the nurses, they usually keep an eye on the patient. Otherwise there is no guarantee that the patient is going to be attended to when needed.

Both trained midwives and TBAs had numerous stories to tell me. When they take patients to the hospital, the women were often left on their own in the delivery room. There were cases where the baby was born more or less by itself, and nearly fell onto the floor.[20]

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[19] And yet these were not uneducated or poor women. Most of the patients would have come from middle-class backgrounds. Their husbands ranged from bank clerks to building contractors and the women themselves had education up to matriculation, year 12 and even B.A. Very few women came from relatively poor backgrounds. This is understandable because as already discussed the hospital is extremely expensive and therefore inaccessible to the poor.

[20] In one case, the baby nearly fell down on the floor, but fortunately the *ayah* was close by to catch it. In another case, a TBA took her sister to the hospital, but noticed another woman who had been left in the delivery room by herself. When she went in, the baby was born, but the nurse came only about an hour later. The TBA was hanging around and when the nurse came she scolded her for being *beyadap* [one who does not know etiquette]. Apparently the TBA replied "you are *beyadap*, you left the woman on her own without any clothes on."

Well over 50% of the patients in the hospital had Caesarian deliveries. Many them also had eclampsia. This was largely because women are brought to hospital in emergencies, when there is a need for a Caesarian delivery, or because they have high blood pressure or other symptoms of eclampsia.

The infection rate after Caesarian is quite high, which may be linked to the unhygienic situation of the hospital. The toilets often do not have water for women to clean themselves, and both the toilet and the delivery ward floor are littered with old bandages.

Every patient has two other women staying with them who must bring their own bedding and sleep on the floor. The patients themselves are provided only with minimal bedding; some of their bedding, such as a quilt, will also be brought from home.

The impression I got of the women being treated in the hospital was that they were in limbo. They thought they were in the hands of the experts, and that they could leave all decisions to them, but this was not the case. Each woman I spoke to had many questions for the doctors and because the doctor would not even listen to them, they asked me, who knew no better! It is not surprising that no one wants to go to the hospital if they can help it. The TBAs do not want to go there because they are always accused of doing something wrong by the hospital staff - usually for not bringing women to the hospital before they tried to deliver themselves.

There are several private clinics where the service is much better. However, the charge is much too high for anyone except for the very rich. In fact, because of the very high costs involved, most of the women brought even to the government hospital for delivery-related reasons are also from middle to upper middle class background. The very poor cannot afford the hospital or the clinic. Emergency or no emergency, they have no choice but to rely on the good will of God.

The Trained Midwives

Trained midwives are perhaps the most hopeful element in this generally very discouraging situation. The midwives in this region were trained by the nuns from the missionary clinic system. Most received their training some thirty to forty years ago; new midwives have been trained for at least fifteen years. Women trained under this system have spent at least 18 months at a missionary training centre, receiving getting practical and theoretical training on midwifery.

There are several missionary clinics around the country, usually part of a Catholic church complex. Clinics are usually also run by the nuns (as in the case of Rupganj, where I did my previous fieldwork). In Noakhali, however, the clinic (the Moriam Health Centre) is run by a lay midwife, Ivy, who was trained by a nun- midwife some 35 years ago. The mission had trained many other women (Hindu, Muslim, and Christian), some of whom still practice in the region. The Noakhali clinic used to be staffed by several nurses until some time in the 1980s. Because of lack of funding, most were retrenched.

There are also a few trained midwives who received their training by working with Bangladeshi doctors in their private clinics. Their experience in these clinics lasted between 6 months to 10 years. For various reasons, they took up midwifery as a profession after leaving the clinic.

Some of the trained midwives have finished matriculation, while others have had at least seven to eight years of education. The most highly regarded midwife is Ivy, the chief midwife at the missionary clinic, who also has paramedical training. People usually pay her Tk500 (US$12.50) per delivery. In addition to the payment, some families may also give a sari to these midwives.

The Moriam Health Centre: The Catholic Mission Clinic in Noakhali

Within the present scenario, the Catholic mission clinic (Moriam Health Centre, henceforward MHC) is the only place where women can expect to receive good attention and health care during pregnancy at a relatively cheap price. While a visit to a private doctor's chamber may cost anywhere between Tk70-100 (US$1.50 to 2.50), plus costs of medicine, the MHC charges no fee, only the cost of medicine.[21]

The usual practice is for women to start visiting the MHC clinic as soon as they can after they become pregnant. They can visit the clinic every month on a Wednesday to have regular check-ups. The cost involved to them is a single admission fee of Tk30 (US$0.75) which covers all their visits throughout the

[21] Apparently they used to give free medicine at an earlier stage, when the MHC clinic was run by the Canadian and American nuns. They were then funded by some donor agencies, including UNICEF. However, all funding has been stopped for the clinic, staff have been scaled down to two - one, Ivy, an experienced and trained midwife and paramedic, and the other an assistant with 23 years experience of working at the MHC. These days, the two women working at the Clinic receive a nominal salary from the mission funds, and Ivy may now and then earn something from her attendance at births.

pregnancy. They also have to pay for whatever medicine, including vitamin and calcium tablets, they receive. Of course, women living a long distance from the MHC often have to resort to hiring a rickshaw, an additional cost.[22]

I observed these midwives at work, and felt they were very thorough and caring in the way they treated the women. At every visit, each woman receives a series of tests to determine if everything is progressing smoothly with the pregnancy.[23] Towards the advanced stage of pregnancy, the woman is usually advised whether she can expect to have a normal delivery or whether she should seek expert help by going to a hospital or a private clinic.[24]

Only some of the women who attend the MHC clinic will eventually call Ivy to attend the birth. Her charge for a delivery is Tk500 (US$12) and very few can afford her services. The clinic staff only receive a nominal salary from the mission for their services and their charge for attending deliveries somewhat makes up for a lack of full salary.[25] In any case, as Ivy's services at the clinic are relatively cheap, these are more accessible to women who at least are told beforehand whether they can have a home delivery with a TBA or a trained midwife, or whether they should consider seeking more expert help.

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[22] Sometimes at a very advanced stage when a woman may not be able to travel to the Clinic due to some complications her family may ask Ivy to call in for a private visit. In this case, the family pays for the rickshaw, and sometimes also a nominal fee varying between Tk20 to 50 (US$0.50 to 1.25).

[23] These include a blood test, in which the level of haemoglobin and water is checked, taking blood from a prick on the finger and checking it against a coloured chart of blood types. The midwives also check blood pressure, check whether hands and feet show signs of too much water, check the woman's weight and whether it is proportionate to expected weight gain, urine test (if it turns creamy after heating it over a spirit lamp then it may mean the woman has problem of leukuria), and finally they perform an abdominal check up.

[24] Ivy told me that the way they conduct their services at the Clinic was established by Sister Monica, a Canadian nun, who many trained midwives always talk about. Sister Monica was a trained and experienced midwife, who took the initiative to send groups of women (Hindu, Muslim, and Christian) to a special training centre on midwifery in Barisal (southern Bangladesh). Several of the local trained midwives received their training through her. The older Bangladeshi doctors in the region also remember her for her expertise as a midwife. It has been said that often she knew better than the MBBS doctors at the hospital.

[25] Moreover, Ivy has also hurt her knee joint (which apparently needs a complicated operation costing upto Tk40,000, US$1000) four years ago and this interferes with her work in a bad way. She cannot sit on the floor - which would be the case in most poor households. She cannot walk more than half a mile at most and the poor cannot afford to pay for rickshaws either.

The village women living within several miles distance from the MHC thus have access to regular check-up during pregnancy (including urine tests, blood pressure, and general physical condition), and advice from Ivy on how to manage oneself during pregnancy. Moreover, through weekly EPI (Expanded Programme on Immunisation) sessions at the Clinic, run by the government, and funded by UNICEF, women and babies also have access to immunization as a safeguard against eclampsia, and various infants' diseases such as diptheria, tuberculosis, polio, measles, and whooping cough.

Some Points of Contrast between TBAs and Trained Midwives

It may be useful to summarize some of the differences between the services provided by the trained midwives (TMs) and the TBAs.

- If women go to the clinic beforehand, they receive regular pre-natal care. TMs usually visit the new mothers and babies for several days after birth.
- The trained midwives are much more competent. They are well trained about the importance of hygiene in birth care and perform their deliveries accordingly. They carry their own delivery kits with the relevant implements. They wash their hands and use gloves, and change the birthing woman into clean clothes.
- TMs use both hands for delivering, not only the left hand employed by the TBAs.
- Although TMs, being local women, are sensitive to the modesty rules and avoid taking off all of the birthing woman's clothes, they take off her *sari* and place it over her bosom. More importantly, they carry out a pelvic and vaginal examination in order to assess the labour situation. We have seen that this is not done by TBAs.
- TMs perform enemas (douche) on the birthing woman and check her blood pressure. Again, TBAs are not in a position to do this.
- Because often Ivy may be called after the birthing mother has been in labour for two days or so, if she feels the case is complicated and needs clinical attention, she tells the woman's guardians to arrange to take her to the hospital. Often she may accompany them. In contrast, most TBAs would find it difficult to establish the causes of long labour and by waiting in ignorance may endanger the lives of the birthing mother and the baby.

- Most TMs, especially Ivy, do not allow too many women and children to crowd around the delivery room. However they allow one or two women (mother, mother-in-law or sister-in-law) to stay and help.
- TMs cut the umbilical cord as a matter of course after delivering a baby. They use scissors which they carry in their delivery kit and which they boil before and after each usage. They also carry sterilised thread in their delivery kit.
- Ivy gives a warm bath to the baby, sponges the mother, and puts on a sanitary pad or uses the pieces of clean old sari to make into a pad. (She says she does not do the cleaning.) She also goes for follow-up visits to see how the baby and the mother and progressing. However, she admitted that because they are so busy at the Centre, she cannot always go back regularly.

How do the Trained Midwives Fare in Terms of Status?

From the above list we can see that Ivy, the MHC clinic midwife, and other trained midwives perform their task of delivery quite differently than do the TBAs. In particular, TMs use both hands for deliveries, uncover the woman for internal examinations, and cut the umbilical cord. If TBAs did the same thing, they would risk polluting themselves unnecessarily and committing *gunah* [sin].

Ivy was not at all concerned about these issues, and yet she clearly commanded much respect from the village society. For example, she was away on holidays for a few weeks and when she returned everyone seemed very pleased to see her. When she went to the schoolyard, some young mothers came and touched Ivy's feet asking for her blessings, a common way of showing respect to older women in this culture. Walking on the streets with her, I observed that the menfolk (of all religious backgrounds) stopped to speak to her, ask about her well-being and so on. While all TMs enjoyed higher status than the TBAs, no one commanded as much respect as the clinic-based midwife Ivy. This was also reflected in the different amounts paid by families to different TMs. Ivy's rate was Tk500 (US$12.50), while others could earn anything from Tk150 to Tk500 (US$3.75 to $12.50).

Conclusion

In considering the relationship between trained midwives and TBAs, a good starting point is the question of Ivy's high status in the community. How can we explain Ivy's status? She carries out all the "polluting" tasks, including the most polluting one of all, cutting the cord, yet she enjoys higher status than the TBAs who avoid doing these tasks. Is it because of her education (matriculation), her training, and her association with the mission clinic? Is it because she has a continuing relationship with the women through the ante-natal services at the clinic? Is it because her expertise, including her paramedic training, is sufficiently recognized and her services enough in demand to enable her to charge Tk500 for a delivery, a quite considerable sum in local terms?

I think that all of these factors play a part. However, there does not seem to be a stream of educated and middle class women ready to follow in Ivy's footsteps. In part this is because the mission system which supported her training no longer has the resources or (in post-colonial Bangladesh) the political strength to maintain its training programme. There are, however, other ways to obtain training if women are determined.

A key issue is the lack of payment, which ensures that only very poor and uneducated women with no real alternative will take up this career. Undoubtedly, if TBAs received a government salary, or if they were able to demand a reasonable fee from the families they assisted, this would help. Thus in the past, nursing was an occupation which was taken up by women in marginal situations (particularly Christians), while these days increasing numbers of women from all religious groups are taking up this profession as it commands a respectable salary in the present times of economic crisis. Again, women from middle class families who work with family planning NGOs now travel wearing a veil and walk long distances. A few years ago, this would not be done by a middle class woman. The low status of the village TBAs is closely tied up with the lack of payment for their services. If they received a respectable salary in local terms, I have no doubt that the job would become much more attractive and its status would rise.

So it seems that there is room for change, provided the government and relevant NGOs are prepared to take sufficient notice of the need for it. However, as long as TBAs are the poorest women in the community, exploited for little or no payment, there is unlikely to be significant change. Here the ideology of *sowab* continues to play an important part, legitimating the exploitation of TBAs

by the wealthier villagers, and maintaining their low status. It would be useful if Islamic authorities could come out against this ideology, as they have in the case of traditional opposition to family planning. This might be an important step in restructuring the whole network of social relations which keeps TBAs locked in a "low status trap". It is only if TBAs somehow gain the status and the income appropriate to the vital work they perform that the work will gradually attract young and educated women who will in their turn be able to make a real impact for the better on the nature of the birthing process in rural Bangladesh.

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