# Proposal: Establishing the Scope and Pattern of Care by Dais during and after Childbirth in Four Cultural and Geographic Settings in India

Until the western medical system was introduced, India's people depended on health care routines that drew from an ancient base of knowledge and skills. One aspect has been the traditional system of midwifery and postpartum care practiced by "dais". Modern maternity care has made many advances and contributes greatly to the survival and wellbeing of mothers and newborns, but at the same time it has failed to carry forward the strengths and advantages of the traditional midwifery system. The colonial medical system looked down upon dais, vilifying them as dirty unscientific practitioners who were only a danger to birthing women. Still, as historical records show, they utilised dais to bring women as cases for doctors to practice caesarean and forceps delivery, etc.

With roots in the schooling of some dais as "ayahs" in a few colonial hospitals, in independent India the training of dais was taken up as a major effort in the '50s. However dai-training continued to fixate on "hygiene" without recognising the supportive and skilled role that traditional dais actually play in the care of birthing women. Beyond normal birth, while it did teach them to detect high risk conditions that need referral, it refused to acknowledge that conditions occasionally *force* dais to face and deal with complications. The need to give dais essential modern skills in obstetric first-aid was precluded by the assumption that modern services will soon spread and reach the unreached areas, but that did not happen in most places. Hence, not only has such training been inadequate, it has actually stopped dais from practicing their traditional skills. Neither have the health services established functioning links with the dais they have trained. At root the medical system has seen dais as creators of risks.

However, during a brief period of roughly three decades from the '70s through the '90s, traditional birth attendants (TBAs) gained global recognition for their importance to local communities around the world. It was part of the wave of consciousness that upheld "primary health care" as a fundamental aspect of human development, which reached a peak at Alma Ata in 1978. During the '80s most countries in the world adopted TBA-training programmes. However, this trend of global health policy support to TBAs in national health programmes declined with the close of the millennium. The main reason quoted was "lack of evidence" that TBAs can bring a reduction in maternal and neonatal mortality. (Neither was there evidence that they cause it.) So the current situation in India is that dais are officially excluded from the childbirth care services provided under the National Rural Health Mission (NRHM), launched as a "flagship" programme in 2005. In tune with the shift in global health policy, the NRHM aims to provide "institutional births" for all women and seeks to prevent homebirths by dais as they are officially considered unsafe for mothers and newborns.

Even so among the poorest communities homebirths still amount to 60 percent (NSS, 60$^{th}$ round) and in remote places dais continue as the only source of childbirth care. In such areas dais not only provide routine care in normal childbirth, they also face obstetric complications without back-up from the medical system. Significantly, according to many reports from ordinary families in such areas, the dais have often been successful where even the local doctors and nurses have failed. They offer many comforts and conveniences during labour and the postpartum period that are not provided by any other care system. Yet most often, the dais are the first to point out their own obvious limitations and the dire need for system back-up.

Part of the reason for dais' official exclusion is the domination of maternity care by an exclusively western medical and public health perspective. As a result, the need for a systematic study of the role of dais has not received attention. This has led to a lack in the evidence base

with regard to their positive traditional practices that may even enhance the survival and well-being of mothers and newborns.

Moreover, the system needs to consider the possibility that…

(a) In areas where services infrastructure is still inadequate, the dais' value may not be only in handling normal birth situations but also in being of help when complications arise and when access to expert referral care is delayed… and that…

(b) By allowing and supporting dai-attended homebirths of women who are screened to rule out the usual conditions of risk, the dais could help reduce the burden upon the overburdened institutions.

Hence we intend to investigate the dais' value in handling screened normal births as well as in stabilising sudden complications before a referral destination can be reached. Ultimately, as the NRHM claims to reach out to the unreached, the dais are important in contexts where poverty and deprivation is entrenched, as in sizable marginalised and remote populations in our country. Reconsidering the role that dais can play is critical, and that is the crux of this research project.

## *The Proposed Study*

The "Jeeva" initiative was begun in 2007 to strengthen the evidence base in support of systemic inclusion of dais and their skilled tradition. It has given rise to a team of researchers with medical, public health and social sciences backgrounds. We have already undertaken two research activities, namely the pilot interviews of dais in Jharkhand in 2009 and current exploratory exercises in the four proposed study locations in Jharkhand, Himachal Pradesh, Maharashtra and Karnataka. In August 2009 we held a workshop that brought various concerned experts together with the prospective regional partners. (*See Annexure 1: Note on the Jeeva Project.*)

As a part of the larger Jeeva research project, here we propose a study in the selected population in four states covering a period of 21 months and planned to begin from July 2010. It focuses not only on investigating the knowledge-and-skill base of the dais but also on recording the systemic dimensions of their relationships within their communities and with other health care providers. Our study design has been facilitated by baseline data from both pilot study and exploratory exercises on parameters such as population characteristics, prevalence of home births, currently practicing dais, status of health services, etc. The total number of dais of all grades of experience and popularity is around 50 per area, totalling around 200 dais, with male dais practicing in one of the areas.

The four study locations are selected for their remoteness, diversity and the presence of a suitable and willing local partner organisation. The local partner organisations are as follow:

- *Jan Chetna Manch,* Bokaro Dt., Jharkhand (Chandankiari Block)
- *Janarth Adivasi Vikas Sanshtha*, Nandurbar Dt., Maharashtra (Dhadgaon Block)
- *Society for Rural Development and Action*, Mandi, Kangra/Mandi Dt., Himachal Pradesh (Baijnath / Darang Block), and
- *Vimukthi AIDS Tadegattuva Mahila Sangha*, Bellary Dt., Karnataka (Kudligi Block).

The partners' role is to support and facilitate the research activity, including interfacing with the village communities and local government and health authorities. All of them took part in the Planning Workshop in August 2009. They have expressed interest in raising their own research capacities and will participate in the local supervision and monitoring.

It is to be noted that this study will be supported by another allied but separate study, also a part of the Jeeva project, which will focus on elaborating the epistemiological dimension of the dais' knowledge base embedded in the childbirth practices and rituals, as reflected through the language and cultural idioms. That study, being longer, in the second year will include prospective tracking of the births that are attended by the dais.

## *Conceptual Dimensions of the Study Problem*

The present study aims is to establish the scope and pattern of care that dais provide to families and women during childbirth up to the end of the first postpartum week, identifying both the diversities and the commonalities. We conceptualise the study problem as embracing three dimensions of the dais' reality:

1. Their base of knowledge and skills, their competence and their cultural rootedness,
2. Their social context and relationships with families in communities, especially the poor and marginalised, and
3. Their relations with existing formal/non-formal care providers and their potential to strengthen maternal and neonatal care services in remote parts.

Our perspective on the problem looks towards partnership and co-operation in the system, not controlling but rather supportive of dais. Assuming that dais would be more acceptable where the health services are weaker – a reality in the remote areas – we probe into their existing relationships with the system, ranging from effective exclusion to actually helping the other grassroots health workers in serving women.

## *Objectives of the Study*

The study aim is to be fulfilled through the following six objectives:

1. To map the dais and among them to identify the experienced dais upon whom families rely, listing them with help of the PHC system (ANMs, ASHAs, AWWs, etc.) and confirming this by group discussions in the communities.
2. To explore the socio-cultural and economic context of villages where the dais work, the dais' relationships with households including caste and class factors, their patterns of work, payment and so on.
3. To retrospectively track births of the last 2 years (identified during the survey) for place of birth, attendants, services provided and outcomes; 33% will yield around 80 births per year per location, or a total of 640 births (80 x 2 years x 4 locations).
4. To document dais' traditional practices from onset of labour through the first week after birth, in both normal and complicated situations, by interviews with 15 dais in each area, or 60 experienced dais, and by direct observation whenever possible. A subset of this objective is to record the dais' use of medicinal plants.
5. To identify a set of "key practices" for prevalence and association with outcomes in terms of the survival and wellbeing of newborns and mothers, by analysis of the dai interviews, birth observations and the birth tracking data.
6. To document the dais' existing linkages with the health services system and other care providers (traditional, modern) by direct observation as well as by analysis of interviews with dais and health personnel, etc., focusing on their relations with ANMs, AWWs and ASHAs as well as RMPs, indigenous healers and NGOs.

From the findings we will provide recommendations to help the Government in making reproductive policy and programmes inclusive of dais and open to their best practices, and so to strengthen the initiatives towards mainstreaming the AYUSH aspect of "Local Health Traditions" (LHT) in national health policies and programmes. Moreover, it may help to enhance the sensitivity of AYUSH personnel to the importance of LHTs and particularly the "dai tradition".

## *The Study Population*

The field areas cover communities with large *dalit* (SC), *adivasi* (ST) and other backward sections. The physical terrains vary from rolling or rocky hills to high hilly and forested ranges as well as ecologically depleted areas. Likewise the villages vary distinctly in structure, from more concentrated habitations to sparsely distributed hamlets.

The total study population is about 40,000, comprising about 10,000 in each of the four locations. The assigned study population allows for quantification of the qualitative data in terms of practice prevalence and association with outcomes. To optimise both qualitative and quantitative dimensions, each location covers contiguous villages located within one or two PHC areas where the local partner organisation is active.

## *Design of the Study*

The twenty-one months' study is designed according to a phased Time-Frame depicted in the annexed chart and summarised in the table given here. (*See Table 1 on page 6 and Annexure 2: Time-Frame Chart for the 21-Month AYUSH Study*). There is partial overlap in the phases and some research activities coincide. Here we elaborate the main details.

### *Phase A: Preparations*

**1) Completion of Preliminary Work:** In the first month we will advertise and appoint the staff, sign the MoUs with the partners, set up the coordination office with CWDS at New Delhi, prepare for the training with translation of materials into Hindi, Marathi and Kannada, and update our review of literature.

**2) Regional Team-Training Workshops:** With the local partner organisation at each of the four locations, we will hold initial 5-day training workshops for the local research teams.

### *Phase B: Baseline Surveys*

**1) Socio-Economic Survey (Survey I):** We will use systematic 33% sample survey of households in each study village to understand the caste/class and demographic profile of villages, their social structure, birthing practices and preferences within specific groups, and the communities' views and use of dais and other care providers. This will help to evolve the criteria for assessing popular/competent dais and identify women who have given birth in the past two years and those currently pregnant. We will carry it out through a structured schedule administered to the adult women in families. Part of it would be open-ended so that free flowing information is recorded on preferences and practices and the reasons behind them.

**2) Mapping of Dais and Identifying Popular Dais:** During the exploratory exercises we have already collected data on the practicing dais. The visits in the survey period will be used to cross-check and collect background information on all dais identified including those left out earlier. This would be done with the help of community members, surveyed households, service providers and the partner organisation in each location. Of these, 15 popular and competent practicing dais will be chosen for in-depth interviewing in each location (a total of 60 dais). For their selection we will make use of community perceptions, especially women's perceptions, about the quality of a dai's work and her accessibility.

**3) Interviews of Formal Healthcare Providers (Survey II):** We will interview primary health care functionaries concerned with maternity care (MOs, ANMs), ASHAs and AWWs for their views on birth practices, role of dais and possibilities/problems of coordination with different providers. The help of ANMs, AWWs and ASHAs will be taken for household listing and records of women delivered in the last 2 years and pregnant women. Each area may have around 10 AWWs and 10 ASHAs, 2-4 ANMs and 1-2 doctors whom we will interview with open-ended schedules for information. Some of these interviews may extend into Phase C.

**4) Observation of Dais' Interactions and Actual Births:** This will be a constant activity of the researchers starting from Phase B and extending throughout the whole field research period of 15 months. It will focus on watching the dais' interactions with families, community members and other health care providers as well as on observing actual births whenever possible, for the details of the childbirth care practices, rituals, how complications are handled and the support provided other health functionaries and peripheral health institutions.

*Phase C: Interviews, Retrospective Tracking of Births*

**1) Training in Qualitative Research Methods:** In each location, an intensive training workshop of 5 days will be held before the next work starts. It will involve not only the local study team (two pairs, each consisting of a research associate and a local field research assistant) but also members of the partner's staff in order to build their long-term local research capacities. We will orient the participants on qualitative research methods, on the birthing process and on common complications. Practice will be given in using research tools, e.g. interview guidelines, check-lists, etc.; guided interviews will be conducted with dais not selected for the study. Emphasis will be laid on listening, observing gestures, recording and not interpreting the dai's statements, and taking care to develop rapport with the dai before starting.

Then the following three research activities will then be carried out simultaneously.

**2) (a) Interviews with Selected Experienced Dais:** Two teams of two researchers will conduct two detailed interviews with each selected dai, through which we will study in detail the dai's social and economic background, her process of learning and her experience of practice in attending to birthing women and newborns. We will look at the way they conduct labour and delivery, the period over which they help mothers, the way they detect and understand problems, and when and from whom they seek help or assistance. Detailed interview guidelines and relevant check-lists will be provided to the researchers for this work.

**3) (b) Retrospective Tracking of Births (Survey III):** Over six months, the previous 2 years' births identified through the 33% household survey will be studied in depth through revisiting those households. Details of place of birth, care provider, whether it was normal or problematic, referred or not, and the outcome would be recorded with special reference to the role played by the dai, positive or negative. The data collected will be cross-checked with the concerned dai and others. In the 33% sample of the 40,000 population, conservatively assuming a birth rate of 25 per thousand, this survey would yield retrospective data on 320 births.

**4) (c) Additional Tracking of Difficult Births:** To add to the understanding of the dais' role in case of complications, taking help of the AWWs, ASHAs and ANMs, households will be identified in their respective villages where neonatal or maternal death has occurred over the last one year, or in which cases a delivery was associated with severe bleeding, convulsions, high fever or other complication for which the woman may or may not have been referred to an institution. The schedule used for birth tracking will be applied to the women concerned in these households to add to the systematic sample survey of births over past two years.

The tools/ instruments (survey schedules, interview guidelines and, case-study formats, check lists for discussions etc.) are currently being developed and finalised for translation.

*Phase D: Cross-Checking the Qualitative Data*

While cross-checking is actually an ongoing research activity relating to the interviews, observations and survey information, over this fourth phase a concerted effort will be made to cross-check the narratives provided by the dais by going to the concerned households and, where cases were referred to institutions, by talking to formal providers. Case reports of selected incidents and experiences will be developed to highlight key issues.

*Phase E: Final Analysis and Reporting*

While data-coding and interim analysis will be done throughout the phases, in this phase both the qualitative and quantitative information will be integrated. A further updating of our literature review will be done. The whole process including writing the Report will require about six months. We propose not only to share the findings with the local administrators but also to work with the local partner organisations to enhance their supportive activities for the inclusion of dais and their positive local traditional practices.

***Table 1: Phasing of the Research Activities in 21 Months***

*Note: The matter in this table corresponds to the Chart conveying the Time-Frame of the 21 Months' Study, provided as Annexure 2 of this Proposal.*

| *Phase* | *Activities* | *Time Period* | *Comment* |
|---|---|---|---|
| A. Preparatory Phase | 1) Completion of Preliminaries: staff appointments, MoU-signing with partners, preparations for training regional field teams; updating of literature review | 1 month (Month 1) | *The regional training follows a 7-day central-level training of the RAs (employed through the allied project) at Delhi.* |
| | 2) Initial training of the regional field research teams at the four partner sites | (5 days at each site x 4 sites) | |
| B. Baseline Surveys | 1) Survey I: Socio-Economic Study of 33% of Households on the Role of Dais | 6 months (Months 2-7) | *These activities coincide or overlap during this phase.* |
| | 2) Dai-Mapping: Identifying Experienced and Popular Dais | (5 months) ( " " ) | |
| | 3) Survey II: Of Service Providers – PHC doctors, ANMs, AWWs, ASHAs, RMPs, etc. | (1-3 months) | *Providers' survey may extend into Phase C.* |
| | 4) Observation: Dais' Interactions and Actual Births attended by the Experienced Dais | (15 months - Months 2-16) | *Observations begin in Phase B and extend through Phase D.* |
| C. Detailed Surveys with Interviewing | 1) Training in Qualitative Methods, (5 days) before interviewing dais | 6 months (Months 8-13) | *The training in qualitative methods and tools will involve the partners as well.* |
| | 2) (a) Dais' Identification and In-depth Interviews: 2 each with 15 selected experienced dais in each location; on work context, content, pattern, relations | ( " " ) | |
| | 3) (b) Retrospective Tracking of Births identified through 33% HH Survey and Dai interviews | ( " " ) | *The three research activities (a, b, c) will be simultaneous.* |
| | 4) (c) Tracking of Additional Difficult Births reported by AWW / ASHA, at household level | ( " " ) | |
| D. Cross-Checking of Data | Cross-checking of dai's narratives, results of birth-tracking and key qualitative data | 6 months (Months 11-16) | *This is to fill the leftover lacunae in the data, case studies etc.* |
| E. Completion Phase | Integration of qualitative and quantitative data, Final Analysis with updating of Literature Review, and Report-writing | 6 months (Months 16-21) | *Now we will initiate dissemination and advocacy activities.* |

## *Expected Outcomes of the Study*

At the end of this study, the following outcomes are expected:

1. A composite portrait of the experienced dais from the four regional locations, including their diversities of caste, culture, patterns of working and relations.
2. A baseline listing of traditional childbirth/post-partum care practices from labour onset through the week after birth, with prevalence and association with outcomes.
3. A listing and documentation of the dais' use of medicinal plants.
4. A detailed documentation of what dais do when faced with a 'lifeless' or weak newborn, with a focus on placental stimulation, including details of timing etc.
5. An assessment of dais' interactions with the health system and other care providers and the dais' perceptions about strengthening these.
6. An evaluation of the dai-training experience from dais' perspective to help improve the midwifery training model for TBAs as well as SBAs.

## *Policy and Programme Implications*

We expect this study to provide pointers to how existing positive traditional practices of dais can contribute to and strengthen the formal childbirth care system. This strengthening could be at the level of:

a) Encouraging dais' active role in community-based birthing care, including antenatal and postnatal care, as partners with primary providers to redistribute workloads and to support safe, culturally congruent and appropriate childbirth services.

b) Improving the referral system with dais' help so that deserving women deliver safely in appropriate institutions and continuity of care is maintained.

c) Improving dai-training programs *as well as* the education of other health professionals who deal with women in childbirth.

d) Improving postnatal care (PNC) through recognising the dais role and skills.

e) Developing the continuum of care by providing for dais to attend the deliveries of women whom they accompany to institutions, also as an aspect of their training.

f) Enhancing equity in services provisioning by improving access to marginalised groups, in view of 60% births in poorest economic groups occurring at home.

g) Encouraging an attitude of genuine mutual support and collaboration between local traditions and formal system by sharing the study results with formal providers.

At the same time, an important application of the findings of this study will be to encourage and support the dais' efforts to organise into state-level associations for realising their potential in promoting the survival and wellbeing of mothers and newborns.

## *Research Support, Coordination and Staffing Pattern*

Overall, the Jeeva project is led by a group of six persons known as the "Shepherds". Together they represent a spectrum of experience in the fields of public health, medicine (including paediatrics), nurse-midwifery, local health traditions, AYUSH, women's health and natural childbirth counselling. Several have long experience in qualitative and quantitative field research methodology. (*See Annexure 3: The Jeeva Shepherds.*)

As far as the present 21-months' study is concerned, the key staff and senior researchers of the project are to be employed on an honorary basis, as they will receive honoraria through a corresponding 36-months study supported independently. (*Please refer to the last paragraph at the bottom of page 2.*)

Among these senior level persons are:

- The Principal Investigator (PI), Dr. Mira Sadgopal
- The Field Research Coordinator (FRC), Ms. Sandhya Gautam,
- 4 Senior Research Associates (SRAs), to be appointed, and
- 4 Junior Research Associates (JRAs), to be appointed.

Under this proposal, the following research and support staff are to be employed:

- 8 regional Field Research Assistants (FRAs), 2 in each study area,
- 8 Link Persons (LPs), 2 each provided by the respective partner organisation, and
- 1 Data-entry-cum-Office Assistant (DOA)
- 4 Translation Assistants (TAs), one in each region.

In each regional location, for 12 to 15 months of fieldwork, the two FRAs will pair with the junior and senior RAs for data-collection. At central level, the DOA will work on a part-time basis as the need demands. While the translation work may be largely handled by the senior staff and the partners, we will need extra help from a TA for each region for translation between the regional language and English of the training and field-guidance materials, qualitative survey data, interview transcriptions, and so on.

## *Project Administration by CWDS*

The Centre for Women's Development Studies (CWDS), New Delhi, officiates for the Jeeva Project, i.e. it submits our proposals, receives and administers the grant funds, and issues the certificate of utilisation (UC). It has also attached one of its junior faculty members to support the project on a regular basis. CWDS is an established institution of national and quasi-government standing supported by the Indian Council of Social Sciences Research (ICSSR). (*See Annexure 4: A profile of CWDS.*)

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### *Annexures*

1. Note on the Jeeva Project
2. Phasing of the 21-Months' Study
3. The Jeeva Shepherds
4. A Profile of CWDS
5. Budget Estimate

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# A Note on the "JEEVA PROJECT"

The **Jeeva Project** is a research initiative of the "Jeeva Collective", a wide-spread network of persons concerned with strengthening traditional dais and the indigenous midwifery system in India and to see them relate appropriately with the formal health services. The initiative was formally begun at a meeting in Bhopal in March 2007.[1]

Six persons known as the "**Jeeva Shepherds**" guide the Project: Imrana Qadeer, Janet Chawla, Mira Sadgopal, Lindsay Barnes, Leila Caleb Varkey and Anuradha Singh. Among them they combine expertise in public health, medicine, midwifery, Ayurveda, teaching of 'natural childbirth' and health care provision to women and children.

The project is officially administered by the **Centre for Women's Development Studies** (CWDS), New Delhi, headed by its Director, Mary John. The Principal Investigator in the definitive Jeeva Study (July 2010-June 2013) is Mira Sadgopal.

## PHASES of the Jeeva Project:

1. **The Pilot Study** (January-June 2009, Jharkhand / New Delhi)

The aim of the pilot study was a preliminary documentation of experienced dais and their practices in the field area of a local partner, *Jan Chetna Manch - Bokaro*. It involved in-depth interviews of 13 village dais in Bokaro district,Jharkhand. A donation from *Insieme*, a group of Italian women film-makers, covered the costs for the field-work (January-February) and Shree Mulay (Newfoundland, CA / New Delhi) gave the remaining contribution for the analysis and report-writing phase at New Delhi. The preliminary report was shared at the August 2009 Planning Workshop and the final *Pilot Study Report* is planned for release in mid 2010.

2. **The Bridge Period** (July 2009 - June 2010)

This year-long period is devoted to preparing for the main Jeeva research. After brief visits to three new partner locations in Karnataka, Maharashtra and Himachal Pradesh, a Planning Workshop was held at the *Indian Social Institute (ISI)*, New Delhi. It brought together the shepherds, the partners (listed below), some researchers and other supporters to share the pilot experience, address conceptual and methodological issues in chalking out the research design, and touch upon the logistical issues. Currently since November we are carrying out four one-month-long '**Exploratory Exercises**' with the partner in each site, to map the dais and delineate the study villages, to profile the cultural and socio-economic parameters in a representative village, and to engage with the logistical issues. At present we are intensifying the search for researchers for two years of fieldwork in each location of the main study.

The costs for this phase are covered mainly by a grant of from the *ICICI Centre for Child Health and Nutrition (ICCHN)*, Pune. Other contributors in this phase have been the *Centre for Health and Social Justice (CHSJ), Sama Women and Health Resource Centre*, and the *Population Foundation of India (PFI)*, all in New Delhi.

3. **The Main Jeeva Research** (July 2010 – June 2013)

The consolidated research project is designed as two partially coinciding and distinct studies in the four locations in the states of Jharkhand, Maharashtra, Himachal Pradesh and Karnataka. The first study, supported under the AYUSH Department's *Scheme for Revitalisation of Local Health Traditions, including Midwifery, for Enhancing Rural Health Security*, is of 21

[1] Initiating a Collective Effort to Investigate 'Heating the Placenta to Revive a Distressed Newborn' (Report of the 'Brainstorming' Meeting held at AICUF Ashram, Bhopal on 22nd March 2007).

months until the end of the 11th FYP period in March 2012. The second study, with support of the ICICI Centre for Child Health and Nutrition (ICCHN), Pune, covers 36 months.

This multi-centric research is primarily qualitative and focuses on the dais in four remote locations in India comprising populations of about 10,000 in each, making up a study population of approximately 40,000. The aim is to record in detail the dais' knowledge, practices and utilisation by the poorest communities and to assess how their services can be supported to enhance the survival and wellbeing of mothers and newborns. Thus, not only do we look at the dais' traditional "knowledge and skill set" in diverse cultural and geographical settings, we also explore their relations in the communities and with other providers of women's health care, as well as the experiences of women in poor communities with birthing and the relative support that they get from the traditional and formal health service providers.

Thus, the overall research objectives are:

1) to conduct qualitative studies with experienced dais and communities on dais' roles and practices in normal and complicated childbirth and their relations with other health care providers in four socio-economic and cultural contexts.

2) to quantify the qualitative findings within the study population including tracking and observations of births, assessment of key practices' prevalence and association with outcomes, and evaluation of the dais' roles in cases of difficult births.

The regional research teams will work in co-ordination with the four project partners, namely: *Jan Chetna Manch - Bokaro* in Bokaro District of Jharkhand, *Janarth Adivasi Vikas Sanstha* in Nandurbar District of Maharashtra, *Society for Rural Development and Action* in Mandi district of Himachal Pradesh and *Vimukthi Women's AIDS Prevention Association* in Bellary district of Karnataka.

The findings of this research are meant to help towards appropriate integration of dais into the Government's National Rural Health Mission (NRHM) and to optimise the dais' potential for enhancing the survival and wellbeing of mothers and newborns.

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## Article for further reference:


- Sadgopal M (2009). Can Maternity Services Open Up to the Indigenous Traditions of Midwifery? *Economic & Political Weekly*, 18-24 April; pp. 52-59.


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Annexure 2

# Time-Frame Chart: Phasing of the Study

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# The Jeeva Shepherds

A group of researchers and health professionals emerged from a collective process which began at a meeting in Bhopal in March 2007 and became known as the “Jeeva Shepherds”. They guide the research concerns of the Jeeva Project.

The six Jeeva Shepherds are:

- **Imrana Qadeer**, originally a paediatrician, is a senior social science researcher in community health. She served as Chairperson of the Centre for Social Medicine and Community Health at Jawaharlal Nehru University, New Delhi, and is a member of the University Ethics Committee for Research. She is on the Board of People's Science Institute, Dehradun, and on the Monitoring Committee of the National Rural Health Mission. She has written extensively in the public health field.
- **Janet Chawla**, holds an MA in Theology. Based in New Delhi, she researches, lectures and writes on the religio-cultural and ethno-medical traditions of dais. For 25 years she taught childbirth preparation classes in Delhi. She directs Matrika (www.matrika-india.org) for research and advocacy on traditional midwifery and non-invasive birth methods. She is author of the book Birth and Birth Givers: The Power behind the Shame (2006).
- **Lindsay Barnes**, holds a PhD in Sociology from Jawaharlal Nehru University and is based in rural Bokaro District, Jharkhand. She focuses on maternity care through Jan Chetna Manch-Bokaro and a local women’s network *Mahila Mondal Samiti*. She has researched on abortion care and reproductive health services and has authored manuals for training dais and ASHA (*'Sahiya'*) in the NRHM in Jharkhand. She is active in the Jharkhand Women’s Health Network.
- **Leila Caleb Varkey**, holds both ScD (Public Health) from Johns Hopkins Univerity and BSc (Nursing) from Delhi University. Based in New Delhi, she worked with the Population Council until 2005. Trained as a professional midwife, she is now a consultant on field based research projects concerned with public health and maternity care services. She volunteers time with groups working to improve women’s health care especially around maternity.
- **Mira Sadgopal**, holds an MBBS degree from Mumbai (1974) and worked as a doctor and rural development worker for 15 years in rural Madhya Pradesh, where she developed relations with dais. She moved to Maharashtra in 1990, based first in Pune and now in Nandurbar. She is a co-founder of the Tathapi Trust for 'Women and Health' Resource Development in Pune (www.tathapi.org) and active in the Indian women's health movement.
- **Anuradha Singh**, a scientist at NISTADS, New Delh, focuses on the crossroads of science and ISMs, revitalising LHTs and promoting people-oriented MCH policy. She served as PI in a study of mind-body in Indian and western theories and now pursues a project of ‘mental health care’. She is board member, PPST Foundation, Chennai, founding member of *Lok Swasthya Parampara Samvardhana Samiti* (LSPSS) and was advisor in the *MATRIKA* project.

Each of the Shepherds contributes work in the Jeeva Project, playing distinct roles at both central and field levels. You can email them care of <**jeevaproject@gmail.com**> or reach them through contacting the Coordinator, Mira Sadgopal +91-9890144106.

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# The Centre for Women's Development Studies (CWDS): A Profile

Source: http://www.cwds.org/aboutus.htm

The **Centre for Women's Development Studies**(CWDS) was established on 19th April 1980, in the International Women's Decade, by a group of men and women who were involved in preparation of the first ever comprehensive government report on the status of women in India entitled *Towards Equality: Report of the Committee on the Status of Women in India* (Government of India) and later associated with the Women's Studies Programme of the Indian Council of Social Sciences Research (ICSSR). The Advisory Committee on Women's Studies of the ICSSR recommended the need for an autonomous institute to build on the knowledge already generated, but with a wider mandate and resources to expand its activities in research and action. The recommendation was accepted by the ICSSR and communicated to the Women's Bureau of the Ministry of Social Welfare, Government of India.

A few months later, under the leadership of late Prof. J. P. Naik, the CWDS was registered under the Societies' Registration Act, 1860 in New Delhi and started functioning in May 1980 with a small financial grant from the Vikram Sarabhai Foundation under the Chairpersonship of Dr. Phulrenu Guha and Dr. Vina Mazumdar as Director. In 1984-85, on the recommendation of a visiting committee appointed by the ICSSR, CWDS began to receive an annual maintenance grant, gaining recognition as one of the Research Institutes supported by ICSSR.

Research has been the mainstay of the Centre since its inception and it continues to respond to contemporary problems demanding investigation by applying inter-disciplinary scholarship in the broad field of women's studies. The choice of research has followed the scope of the Centre's faculty within the limits of its resources, with a gradual growth in outreach in terms of the topic range. The spectrum of research projects currently underway includes electoral governance, citizenship debates, gender in local governance, declining female child sex ratio, child-care under NREGA, women's work, health and family life, vulnerability and marginalisation, gender and migration (including nursing), etc. (For narrations of research projects and related activities, please visit the website: **www.cwds.org**.)

Since March 2009, the CWDS has supported the Jeeva project's initiative to investigate the context and practices of traditional dai-midwives in diverse locations in India. It has handled the grants that came for the Pilot Study, for the Planning Workshop (August 2009) and for Bridge Period (July 2009-June 2010). Since April 2010, it has dedicated part of the time of one of its junior faculty members in regular support of the Jeeva project's research needs.

CWDS is headed by:

- Prof. Mary E. John, Director. She holds a PhD degree in Sociology and has worked for two decades in the fields of women's studies and feminist politics. She was Associate Professor and directed the Women's Studies Programme at JNU from 2001-2006. Recently she has studied women's power in local urban governance and the declining sex ratio in north-west India.
- Prof. Indu Agnihotri, Deputy Director. She holds a PhD degree in History and she focuses on the areas of 'gender and history' and the Indian women's movement.

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