Report of the 'Brainstorming' Meeting held at AICUF Ashram, Bhopal on 22nd March 2007:

Initiating a Collective Effort to Investigate 'Heating the Placenta to Revive a Distressed Newborn'

The indigenous practice of *'heating the placenta to revive a newborn infant'* has been identified in various regions of India and in Bangladesh.[1] In order to initiate a collective effort to investigate the practice in India along with dais (traditional midwives) and others, a group of persons got together for the first time at Bhopal on Thursday, 22nd March 2007 (11 am to 7 pm). A larger number of persons had individually expressed their support for this effort.

An informal beginning...

Getting together informally without a 'project' or 'funding' in place was seen as an appropriate way to begin this initiative. In the search ahead of us we will be working with women whose lineage extends from an ancient indigenous tradition of midwifery that has always been informal and nobody's 'intellectual property'. Even so, this effort calls for intelligent, committed and collective efforts according to a commonly worked out understanding.

The small and mixed group of 13 participants came from six States of India – Andhra Pradesh, Delhi, Gujarat, Jharkhand, Madhya Pradesh and Maharashtra. Eight of them were familiar with the practice in the sense of having heard dais speak about it. Among them three had seen it practiced by a dai and two others had even had occasion to use the practice herself to revive a baby. Five participants have medical qualification: 3 BAMS: Lalita, Shobha, Sulochana, and 2 MBBS: Mira, Sathyamala (who is also a qualified epidemiologist). One is a professor of naturopathy (Satyalakshmi) and one (Lindsay) runs a maternity care centre with a women's organisation (Jan Chetna Manch). The rest are active in social action and research efforts or organisations, two of which are directly related to dais, namely the Gujarat Dai Sangathan[2] (Shobha) and Matrika[3] (Janet).

The participants were given background materials most of which are provided separately with this report – including a concept note with 6 annexures[4], a note and an article from two persons who could not attend, a testimony about using the practice, and suggested guidelines for field observation and documentation from the Matrika experience.

Welcoming the participants, Mira Sadgopal related how nearly 30 years ago she had first witnessed with awe the practice of 'placenta-heating' by a dai in Hoshangabad District of Madhya Pradesh. It had taken so many years for her to reach a stage where she could devote the time and effort needed to initiate and sustain a focused investigation. Thus, today's meeting was long awaited.

The participants

1.	Anu Gupta	Dewas, MP
2.	C. Sathyamala	New Delhi
3.	Chhaya Sharma	Seemapuri, New Delhi
4.	Devika Biswas	Ranchi, Jharkhand
5.	Janet Chawla *	New Delhi
6.	Lalita Jamre **	Badwani Dt, MP
7.	Lindsay Barnes*+	Bokaro Dt, Jharkhand
8.	Mira Sadgopal **	Pune, Maharashtra
9.	Rashida Bi **	Bhopal, MP
10.	Satya Lakshmi	Hyderabad, AP
11.	Shashi Maurya +	Bhopal, MP
12.	Shobha Shah *	Bharuch Dt, Gujarat
13.	Sulochana Harshe *	Pune Dt, Maharashtra

* *...had heard of the practice from dais.*
** *...had seen it practiced by a dai.*
\+ *...had experience of using the practice.*

Note: Some other persons joined for some time as observers: Champa Bahen (Bhopal), Madhuri Jadhav (Pune), Shanta Ranade (Pune), Suhas Kolhekar (Pune), Sushil Joshi (Hoshangabad), and Tultul Biswas (Bhopal).

- - - - - - -

Acknowledgements: Thanks to the Kamala Sadgopal Nyaas, Bhopal, for meeting the venue and food expenses, to Seema & Shashi (Sahyogini Mahila Sansadhan Kendra, Bhopal) for local arrangements, and to Sushil Joshi for overnight translation of the concept note into Hindi.

[1] See the 'List of Reportings' (Annexure 3 to the Concept Note), in background material provided with this Report.

[2] Gujarat Dai Sangathan, registered in 2005, is guided and convened by a group of 9 NGOs; it has about 2000 dais as members; the president & vice-president are dais.

[3] The Matrika project, now registered as a trust in Delhi, explored indigenous birth knowledge and practices with dais of Delhi, UP, Bihar and Rajasthan, and advocates for them.

[4] Annexures: 1. Placenta (fact-sheet), 2. Mira's account (since 1978), 3. Table of reportings, 4. References list, 5. Questions (categorised), 6. Two years' feedback, 2005-07.

Those who couldn't participate

Mira read out the names of the invitees who were not able to participate in this brainstorming for various reasons. Most had sincerely and even emphatically said they hoped to be a part of this effort. Numerous others would have been interested in this initiative and it was hoped to involve them at a later stage at State and regional levels. The thirteen participants gathered at Bhopal at their own expense were asked to consider themselves as meeting on behalf of a much wider concerned group.

Concerns expressed during self-introduction

During the self-introductions, a few participants expanded on their interests and concerns. This helped to set a tone and direction for the meeting.

Sathyamala is a researcher into public health concerns and an activist on health and justice issues with a long-time interest in community health workers. Depending on the set-ups in which they work, health workers can play the role of 'lackey' (servant of an oppressive system) or 'liberator' (helping people resist injustice and oppression).[5] For some years she has focused on experiences of women in rural and urban areas, seeing the need to understand their native wisdom. Figures today show that for minor ailments poor people go to the private medical sector but for major illnesses and injuries they continue to depend on the public health services; but with degradation of the public services many don't go anywhere as they can't afford it. In Seemapuri (Delhi) she and Chhaya find 80% of births occur at home despite a nearby maternity centre equipped under the World Bank Scheme. Evidence now shows that urban women's health is worse than rural women's health. Sathya's interest in 'placenta-heating' is in examining the potential of existing supports around childbirth, chiefly in view of WHO promoted medical interventions to reduce neonatal mortality. However, she warned against glorifying indigenous practices without basis. She also cautioned about the post-WTO patent issue implications. She suggested that this group needs to build up a 'new constituency' for this project.

Shobha Shah is a BAMS doctor from Gujarat who works with Seva Rural (Jhagadia, Bharuch District). This is one of the NGOs that jointly established the Gujarat Dai Sangathan and it acts as the secretariat. Seva Rural has trained over a thousand dais. She knew of placenta-heating as a traditional practice, and those working with dais in other Districts in Gujarat have reported it being widespread. However, at Seva Rural up to now they have been advising dais not to waste time in heating the placenta when a newborn is in a state of asphyxia. The attention being given to it through this initiative was making her think again.

Janet Chawla began as a natural childbirth educator in New Delhi in the 1980s when her children were small. Quickly disillusioned with the overuse of invasive obstetrics in the western medical set-up, she began researching dais and traditional birth culture. In the late '90s she and her co-workers in the Matrika project held three workshops in four areas of North India – Rajasthan, Punjab, Delhi and South Bihar (now Jharkhand). In the workshops they inverted the usual 'training' model, asking dais to train them about birthing tradition, practices and insights. Matrika maintains that evaluations of dais as being 'unskilled' are invalid as they lack perception into indigenous frameworks of understanding and since they conclude from an exclusively biomedical perspective.

After doing her PhD in the mid-1980s at JNU, Lindsay Barnes went to live in a village in Bokaro District, Jharkhand. Since the last 10 years she has been involved with local women in a health-centred micro-credit initiative under the banner of Jan Chetna Manch. In absence of any effective Govt maternity services, JCM runs a 'first-referral' childbirth care centre where they handle difficult cases or refer them if necessary. Local dais are important active members of JCM. Because of 'good work' the Jharkhand Govt Health Dept has just certified their centre for provision of maternity care even though they don't have a regular doctor! Lindsay's concern, beyond the importance of the 'placenta-heating' issue, is how to effectively press the Govt for accountability and provision of standard maternity health services and not to play helplessly into the game of 'privatisation' that is going on globally. Lindsay has been engaged by the Govt to write the ASHA ('Sahaayya') training manuals for Jharkhand State's NRHM, an interesting and frustrating experience. Lindsay hopes to build up a 'dai sangathan' in Jharkhand. She is also part of a network of women health activists in the State, and a supporter of the State-level Jan Swasthya Abhiyan.

Anu Gupta, with the Dewas field centre of Eklavya for over two decades, recalled her participation in 'Shodhini'. It was a collective women's health initiative of seven regional groups in the 1990s that arose from a 'self-help' workshop in Tamilnadu facilitated by Rina Nissim from Geneva. The regional participants worked with local women healers over several years to explore the use of herbal medicines. Their findings are contained in the book *Touch-me, Touch-me-not*.[6] Anu was very glad that a similar collective initiative of women is again arising at this meeting, and she hoped to participate at Madhya Pradesh level.

Lalita Jamre, now a final-year BAMS student at Bhopal, is a member of the Barela tribal community in Badwani District. She said she has struggled for her education, doing manual labour in her village in order to pay her fees and buy her medical books. She also received support from some activist friends in Madhya Pradesh. Women and some men in her community

[5] The book *Taking Sides: Choices before a Health Worker* by C. Sathyamala, 1987 is a bench-mark manual for the training and guidance of health workers as 'liberators'.

[6] *Touch-me, Touch-me-not: Women, Plants and Healing*, by the Shodhini Collective, 1997.

traditionally practice midwifery and still use this method to revive babies. Having seen her mother and aunt do it, she has been wondering how it works. Hence, she is glad to be joining this initiative.

Eye-witness experiences...

In the group there were several persons who had actually seen 'placenta-heating' being done to revive a newborn and each was asked to speak about it.

Badwani, Madhya Pradesh – Lalita

Just three months ago Lalita had seen her mother, a dai, use this technique to revive a baby, surrounding the placenta with burning coals. All the dais in that area (Badwani, MP) use this practice, she said, even her *mama* (maternal uncle) and her aunty. It may take up to 20 minutes or more to revive a baby. In the *Barela* tribal community men also play the midwife role because it is easier for them to move through the hilly terrain alone at any time. Lalita agreed to carefully write up her observations about the midwifery tradition as she had experienced it so far among her people.

Sohagpur, Madhya Pradesh – Rashida

Rashida Bee now lives in Bhopal and is a leader among the survivors of the Bhopal gas leak disaster. But she was born and brought up in Sohagpur Tehsil of Hoshangabad District in the 1950s and '60s. Her aunt had 17 children, of whom 3 (1 female, 2 males) had been revived at birth by this technique. In two cases the placenta, with cord still uncut, had been placed in warm water ('pumping' it) and for the other it was directly heated with burning dung-cake coals. As she recalled, the placenta would be heated for awhile, between 20 to 45 minutes. Even now she meets her male cousin off and on and he is alive and well! The dais in her community at Sohagpur are Muslim.

Bankhedi, Madhya Pradesh – Mira

Mira told of seeing placenta-heating for the first time around 1978 in Palia Piparia village of eastern Hoshangabad District, MP when she was a member of the Kishore Bharati team.[7] After a prolonged and difficult labour, the baby was born limp, pale and appeared lifeless. The dai Gomtibai, elderly and blind, called for '*baber*' grass to burn and place all around the placenta. After only a short while, first the child began to move its lips. Then it uttered a small 'peep' and then began to cry, first softly and then normally. After that over the next 15 years, Mira saw this done on two other occasions. Oddly, the last time it was done by a dai on an obviously dead baby (stillborn following death in the womb) without response. She met the first child 17 years later as a strapping youth.

[7] See Mira's full account in the background papers annexed.

Bankhedi, Madya Pradesh – Shashi

Shashi recounted how, about 20 years ago when in the Kishore Bharati team, she was attending a fellow staff member having her 3rd child.[8] Mira was not there at the time. As in the last birth, the dai from the village was called. The labour was not strong and the dai said it would be better to take her 'to the town' for delivery, but the mother refused. After some time a 'healthy' male child was born but he did not cry or move. Remembering what she had heard from Mira about local dais heating the placenta, Shashi called for dry grass and burning coals from the wood-stove. She set the grass on fire and placed it and the coals around the placenta, which soon began to make crackling and sputtering sounds. As she gently massaged the cord in the child's direction, he started to move and open his mouth. Then with the dai's help, she held him up by his feet, patting his back, and soon the child cried.

Mira pointed out that Shashi's account is significant as an instance of a woman (not a dai) with middle-class urban yet Hindi-educated background deciding in an emergency to use this method. Ironically, the dai herself appears to have become temporarily 'deskilled' in the ambience of educated persons in this NGO[9]. She happened to be daughter-in-law of Gomtibai, the blind dai mentioned in Mira's account. She must have known about the technique, and if in a village home setting, Gangabai herself may have heated the placenta without hesitation.

Chandankiari, Jharkhand – Lindsay

Lindsay described a fresh experience from just a week back when a baby was born in their centre with neonatal asphyxia (not breathing after birth). In line with the normal procedure there, she had been using an ‘ambu bag’ for 5 minutes but the baby didn't start breathing on its own. Recently having heard local dais describing this technique, she called for a vessel of warm water that was near at hand. She submerged the placenta in the water and began pushing it with pumping movements. The baby then made a few gasping sounds and started to breathe on its own.

Reports from different regions

Annexure 3 of the Concept Note is a 'Table of reportings' about the practice spanning a number of decades, compiled by Mira. Only a couple of them are from printed literature and the rest by oral testimony. These reports have come from 11 Indian States (Andhra Pradesh, Bihar, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Maharashtra, Punjab, Rajasthan, Tamil Nadu and Uttar Pradesh) and from 3 sub-Districts of Bangladesh.

[8] See Shashi's testimony in the background materials.

[9] Kishore Bharati, known for initiating the 'Hoshangabad Science Teaching Programme' (HSTP) with the Education Department of the Government of MP in the 1970s-'80s.

In all these reports, the technique of 'heating the placenta to revive a newborn' is common. But there is considerable difference in the way the placenta is heated and the temperature to which it is heated. The placenta may be

- → immersed in luke-warm water, either 'pumped' or lifted rhythmically in it, or
- → wrapped in a hot steaming towel (dipped in boiling water), or
- → touched/pressed by an iron pan or 'tava' filled with burning coals, or
- → surrounded by burning coals or grass (or even paper), or
- → tossed with burning coals in a basket, with circular movements, etc.

Often such heating is accompanied by massaging or rubbing the cord in the newborn's direction. When asked why it works, dais say either that it is the 'life force' (*jeeva*) in the placenta, or that they are moving the 'warmth' (*garmi*) from within it into the baby.

Janet said the Matrika project's finding of the practice being widespread in four States suggested strongly that it is effective in improving the survival chances of newborns and she was sure of its public health importance. Moreover, that oxytocin misuse with neonatal asphyxia was found to be increasing.

Questions arising from the accounts

At the outset, Sathya cautioned that we cannot hold evidence of widespread use alone as proof of effectiveness. Also, to enable us to make any reliable suggestion about the public health significance, our initial study will need to be specifically geared. Ultimately, to be conclusive on both of these issues, '2nd phase' research would be required.

Shobha expressed her surprise about the delay between the child's birth and heating the placenta (sometimes the dai is called only at that time) or in the response of the infant to the practice. She was also concerned about hypothermia (the baby's body losing temperature). From a 'medical' perspective, there would be a number of questions:

How much of a delay occurs between the birth and the heating? For how long is the heating continued? How much time is needed for the newborn to react? Is anything else done at the same time? How long does the placenta itself remain 'alive'? Is there not risk of 'toxic shock'? ...infection? ...hypothermia? ...what about later milestone development?

Mira agreed that these questions are important. Regarding the delay she had thought a lot and a fact had occurred to her that might be significant. Before breathing and lung respiration begins, in a sense the newborn is still a foetus. Its blood contains a special haemoglobin type (foetal Hb) adapted to draw oxygen from the mother's blood. From the time the newborn cries and for the first time takes in oxygen-filled air from the lungs, the foetal Hb gets gradually replaced by adult Hb which is geared to pick up O_2 from the lung air. Might it be possible that the foetal Hb protects the newborn (to some extent, for some time) from the effects of oxygen lack?

Ultimately, the bio-physiological question would be, *What actually happens by heating the placenta (by the various methods) which contributes to reviving the baby?* It was suggested that we not only look for answers in western bio-medical terms, but also in terms of the 'Asian medicine paradigm'.

The issue of 'de-skilling' of dais was also raised. Lindsay remarked that in Jharkhand dais themselves are going after the *jhola-chaap* doctors to give the oxytocin injections. Sulochana said in her area of Maharashtra a new surgeon has come and gives the dais Rs.100 on the spot when they refer childbirth cases to his hospital. Thus private practice may undercut incentives offered by Govt, such as under the NHRM's Janani Suraksha Yojana.

There was some discussion about dais' and people's resistance to cutting the cord before the placenta comes out. This is something that prevents women from going to hospitals. A dai in a Matrika workshop once commented,

"For nine months the placenta and baby are together. What is the hurry in cutting the cord?"

("Nau mahine tak to aanval aur baccha saath mein hain. Is ko itne jaldi kaatna kyon?")

Sathya said she had understood from dais that their worry is that, if you cut the cord when the placenta is still inside, the stub-end may be drawn back into the uterus and the os might close and prevent the placenta from coming out. (This is discussed more in 'Issues of cultural sensitivity and paradigm', below.)

Participants raised concern about the recent upsurge of interest in placental tissue as a source of bio-active substances and stem cells, and its commoditisation on the international market, linking with patenting issues. Trade tentacles could extend through the World Bank funded NRHM which aims for all births to take place in 'institutions'. Sathya also mentioned that Placental membrane is used to treat severe burns,. In some places Matrika found that dais rub the placenta over newborns' skin to reduce body hair later in life. In this project, will we prepare ourselves to face the implications?

Why are we doing this study?

Lindsay posed the question – *'Why are we doing it?'* It made the participants think and answer:

- If this practice is effective in reviving asphyxiated newborns, it could actually be of large public health significance in reducing neo-natal mortality without dangerous or expensive intervention.
- In view of dais' precarious and confused status within Govt policy which is blind to their traditional skills and actual contributions, bringing out their positive role and advocating for them is important.

- Through this effort we can challenge the dominant paradigm of 'training' of dais and health workers that treats them as extensions of a narrow health system, knowing little of their consciousness, knowledge and history.

Clarification about phases of study

In the concept note Mira had suggested four categories of investigative concern: ethnography, historiography, bio-physiology and public health. As the discussion developed, it became clear that these concerns have mutual linkages and they are not watertight. A more practical way is to look at the concerns phase-wise:

- Phase I: Field Observation and Documentation

  This activity is basically ethnographic but it will need supplementation by parallel reviews or 'homework' in areas of historiography, bio-physiology and public health. (See list, later.)

- Phase II: Follow-up Research Projects

  Such studies are expected to arise from findings and insights provided through Phase I; they would be of experimental or quasi-experimental nature in fields of bio-physiology / public health, dealing with bio-effectiveness, neonatal survival, etc.

Elaboration of Phase I planning will be part of the proposal-writing to be done soon, and will need inputs from the regional groups intending to participate.

Clarifications about focus, scope (phase I)

With the first phase specified for field observation and documentation – ethnographic in essence, but keeping the other three concerns in mind – the question of focus and scope was raised.

Should placenta-heating alone be studied or should we take in all traditional post-partum childbirth practices related to survival of newborns?

When someone suggested we might look at the incidence of hemorrhage and placental retention. Janet warned, *"Beware of 'scope-creep'!"* Sulochana suggested we clearly focus on what dais do in 'difficult situations' when called upon to revive a newborn.

Even so, participants felt it necessary to consider the cultural, social and even political environments in which we will be finding ourselves.

To what extent do we need to investigate the caste dynamics relating to childbirth care?

Sathya said that (from a study she and Ritu Priya had carried out) in Jaunpur Dt of Uttar Pradesh a number of decades back dalit groups had taken a common vow not to pursue certain traditional occupations considered 'polluting'. Specifically, they would neither cut the umbilical cord nor skin animals. It was known as the '*naal-mhaveshi'* boycott. So as a result in parts of UP apparently there is no indigenous traditional dai. The women who perform these tasks are the family members or the members of the dalit community who have migrated from outside. Janet disagreed with this as she knows of traditional dais in UP. She mentioned Sarah Pinto's work in Sitapur Dt suggesting that existing caste divisions in birth work far precede the modern dalits' turn away from traditional occupations. We need to understand the real situation, as well as to delve into ritual pollution and its associated political economy.

In some if not all of the regions, we will be documenting the role of dais in contexts of the ongoing NRHM[10], where in some states dais have been made into ASHA[11]. We need to make note of the dynamics in these contexts. Anu suggested we take note of role of the ANM and her relationship with dais.

Janet expressed her concern that the mother of the baby should not be excluded, with all the focus centering on the placenta-child relationship.

Hence, it was decided that the focus would be on the immediate post-partum period (from emergence of the placenta upto the end of the first week). It would include cord-cutting practices and methods used for survival of the baby, both traditional and modern. Oxytocin use would also come in. The mother-child-placenta would be considered as a conceptual unit (a triad) and also as separate relating entities.

Spade-work to identify areas of prevalence

Some groups already know that the practice exists in their areas, but others are not yet sure. Hence a certain amount of 'spade-work' needs to be done with the objective of identifying communities where the practice is prevalent to some extent so that it can be studied. At the spade-work stage, one should go to dais themselves and ask about what they do in case a child is born in apparently lifeless condition, not crying, breathing or moving. Do not ask directly, "Do you heat the placenta to revive a baby?" If you do not find the practice, you may then tell the dais and other women about how it is found in some other places and record their response to this news. Spade-work needs to be done in the next two to three months (before July) for the documentation to start thereafter.

Strategy and methodology of documentation

The basic principle of documentation is simple: carefully note what we see and hear (*jo dekha, vo likha*) in order to record what is actually happening among the people. Commitment to the task is not that simple – it requires a consensus among us and guidelines on what to look for and how to observe. The Matrika project's guidelines would be a help, but our own would have to be specifically worked out with regard to content, methodology, writing / translation from local language, etc.

---

[10] National Rural Health Mission, Government of India.

[11] ASHA = Accredited Social Health Activist.

The methodology would begin with focus group discussions (FGDs) to break ice, then interviews and possibly workshops. In localities where the practice has been found through spade-work, it should cover the elderly dais and older women in families. Someone asked if there would be a 'quantitative' aspect, and the answer was 'no' as ethnographic work is qualitative by nature. However, there would be an attempt to assess the extent of deskilling. Any and all outcomes of placenta-heating, positive or negative would be sought, with care to avoid leading questions.

Between the regional group initiatives, there would be common goals, guidelines and similar timelines. There might be some practical flexibility (to be specified) but the group felt there should be no flexibility in the methodology to maintain its validity. We need to have one more meeting (all regions together) to prepare ourselves with self-training for FGDs and interviews. This may be in August end (4-5 months hence). Before that, groups should complete their spade-work.

The group felt we should be cautious in using audio-visual documentation technologies, including camera, taping and videofilming. Such efforts can be contrived and critically interfere with spontaneity as well as content and meaning. Junuka Deshpande has reflected thoughtfully in her feedback on the pitfalls of documentation technology.[12]

In order to optimise the capability of our study to influence public health officials, Sathya suggested we could refine our investigation methods. We could even design the study to be prospective, documenting the technique as it is actually being practiced and not only having it recalled retrospectively. There is a need to take care of certain ethical issues. *Can we train the dais to document?* This may be more feasible in dai organisation contexts, such as in States like Gujarat and Jharkhand (if Lindsay's idea takes off).

The issue of time-lines was only briefly touched. Most said they would be able to devote time and focus only from October 2007. The investigation would perhaps take from 6 to 18 months. This would become clearer through the regional initiative processes in the coming two to three months.

Issues of cultural sensitivity and 'paradigm'

Most work with dais in our country (training, etc) is done within a western medical paradigm or framework of biological science, by which everything that dais do is interpreted in terms of how western-educated health professionals comprehend it. If it doesn't fit in with that understanding it tends to get dismissed as 'wrong belief' or 'superstition'. As Shobha reported from Seva Rural's context in Gujarat, dais' practices may be accommodated by classifying them into harmful, harmless or helpful, and this judgment is made according to current western obstetrical practice and germ theory. But as Janet pointed out, the dais' world is very different and much older that that perspective. Their view of reality entirely contrasts with western bio-medicine.

To appreciate this contrast we have to see the basic differences between the Asian and Western medical systems. Asian systems of health and medicine are based on energy and movement, whereas western medicine (or 'allopathy') is based on material organs and matter. Allopathy is historically based on knowledge of the material body derived from post-mortem dissection (autopsy) whereas Asian systems (including *ayurveda*, *unani* and *siddha* in India) have been derived from perceptions of body energy and energy flows. According to ayurveda, the placenta is seen in terms of 'life force' energy and during labour the flow of energy is mainly geared towards downward and outward movement (*apaan vaayu*). Otherwise (as in breathing or in pregnancy) the 'life energy' tends towards upward and inward movement (*praan vaayu*).

When asked, the reason that many dais give for not cutting the cord early is that the placenta will go up into the chest and kill the woman. By this we should realise that they do not mean the physical placenta will literally go all the way up into the chest, but rather that the body energy that should be pushing it down (*apaan vaayu* in Ayurveda) now moves in the reverse direction upwards. We need to grasp this perception – dais are not stupid. Janet related an instance when a dai (a sweeper in Delhi) spoke about a birth where the placenta was heated even after the cord was cut and the child revived. Leaving aside the 'effectiveness' issue, Janet's point was that dais perceive a connection that is energetic and may not always be literal. Likewise, treatment of the placenta after the birth is a matter of special care as it is believed to retain power. For instance, as many women still believe, if the placenta is taken by an infertile woman, she may conceive a child but the newly delivered mother may become infertile.

In the context of oxytocin misuse the idea of the 'ritual use of scientific medicine' was raised, and the switch from traditional to 'modern' often being only in form. Satyalakshmi observed that for people oxytocin is becoming like a routine 'tonic injection'.

Areas for preparatory study (homework)

Out of the discussion and from the 2 years of feedback some areas for preparatory study emerged:

- the known bio-physiology of the placenta
- knowledge of placenta from non-western sources
- neonatal asphyxia: western / non-western view
- role of the TBA today and history of the 'dai'
- status of oxytocin misuse, particularly in India
- institutional births: Govt policy/implementation &
- the patents' issue as it may apply to the placenta.

[12] See Table of 2 Years' Feedback, earlier mentioned.

Follow-up research concerns (phase II)

Placental bio-physiology poses investigative problems of 'second-phase' nature. Up to now most of us have been thinking of placental bio-physiology only from the western bio-medical perspective, but is this legitimate? There was an appeal to consider it from an Asian '*jeev-shaastra'* (life-science) perspective. For instance, the knowledge base in *ayurveda* is radically different and undoubtedly would include a view of how the placenta 'works'. So while the western paradigm has strong legitimacy, we should be careful not to treat it as exclusive and not to see the study of non-western sources as only a part of 'historiography'.

At some point there will be a need to assess the incidence and causes of birth asphyxia and its part in neonatal mortality – with or without placental heating. Also, for babies so treated (by placental heating), what are the circumstances and what might be the outcomes (in terms of neuro-developmental morbidity) in the later life of the child. Lindsay's impression is that birth asphyxia is a common cause of mental retardation and death of newborns in her area, and most probably oxytocin misuse is playing a part in it.

Shobha posed the question of whether the response of the neonate to placental heating will be different if it is premature or full term babies? Lung function is immature in premature neonates.

We expect that bio-physiological research would inevitably get tied up with the issue of bio-patenting and knowledge ownership, and so to prepare for it.

Potential advocacy-related issues

Are we going to promote this practice? If so, it brings up certain ethical issues. Do we have the methods required to negotiate them?

The issue of oxytocin abuse in labour – harmful to both mother and baby – and what to do about it should certainly concern us. It is a violation of women's health and right to 'safe motherhood'.

Aside from excluding dais and falling short of meeting women's rights to appropriate childbirth care, the NRHM is driven by the anti-social trends of privatisation and market commoditisation. What is our stance vis-a-vis the NRHM itself?

In this post-WTO era, we would have to worry about patent issues. To what extent do we need to get involved? This is one of the issues listed for 'homework'.

Co-ordination and operational aspects

All those who came to this brainstorming meeting were present as individuals who had come together out of personal concern at their own expense. Most are linked with organisations that we hope will support this initiative. Having convened the first meeting out of long-time involvement, Mira was asked to continue as co-ordinator. She accepted this responsibility trusting that the initiative now belongs to a larger number of people and the tasks would be shared. The various persons present had made several tentative committments. For project implementation, an accountable group would have to be named. Over the next couple of months, this group should become evident through their responses and engagement.

At this meeting there were persons from six regions (Andhra Pradesh, Bihar-Jharkhand, Delhi, Gujarat, Maharashtra & Madhya Pradesh). Persons from more regions may come forward in response to the meeting report. Informal regional level meetings may be called. To view the spectrum of supportive persons and their tentative level of involvement, Sathya took the list of 2 years' feedback and got us all to grade them into 1st line, 2nd line and 3rd line support categories. They would all receive the meeting report.

Participants wanted 'the group' to meet regularly, as often as feasible, with activity aiming towards 'learning for ourselves' through sharing in workshops along the lines of the Shodhini experience.

The coming months would see several tasks done. (See the list of commitments, below). A proposal would be written and suitable funding secured. The guidelines for field study would be evolved. The regional initiatives would take shape, and some preparatory homework would be done.

Project proposal and funding: principles

Funding adequate to cover essential expenditures would be necessary for consistent work in the various regions. The work style should be low-key, including workshops, travel, etc. If less funds are needed by any group, they should surrender the extra amount to the common fund for other use. The funding needs will depend on the study size, training required, etc. Any group would also have the option of not taking funds. The project proposal would cover "what, why, who, where, when, how and how much". The budget should include all the reasonable expenses including translation between the languages. Consideration should be given to follow-up.

An ICMR research opportunity that had come on mfc website (forwarded by Saras Ganapathy) was discussed; it was rejected as it is US AID funded. A Gates Foundation-supported project in UP, mentioned by Janet for seeking access to their data collected on indigenous traditions, was also discussed briefly. It was not seen as a funding option, though we may inquire about the data through a friend who is currently working in the project.

At this point several principles were commonly decided with regard to the funding, as follows:

- only 'solidarity' funding from smaller funders and individual supporters, or from specific Govt of India sources, would be sought and accepted; there should be no 'strings' attached.
- funds should cover expenses for coordination and for a number of regional initiatives.
- financial support for each regional initiative would be equal or equitable.

- support would be for personal commitments in the region, not in terms of NGO partnerships.
- each regional group would accept a common quantum of work, guidelines and similar time-line.
- financial support would not cover all the expenses in a region; extra expenses would be met locally.
- project funding would be routed through a single NGO (probably in Maharashtra).

Some possibilities for funding sources were mentioned (and there may be others):

A) Government of India:
1) Dept of Science & Technology (DST)
2) Dept of AYUSH, Ministry of Health & FW
3) Indian Council of Social Sciences Research (ICSSR)

B) Foreign:
1) Global Fund for Women, USA
2) Mama Cash. Netherlands
3) Save the Children (country?)

It is also possible that some individual friends abroad might help support the project through donations.

Serious "second-phase" research projects (historiography, bio-physiology, etc.) may be taken up through parallel independent funding. A policy of support towards these projects from Jeeva would need working out – no decisions were made.

Presently, we would modify the concept note for putting out feelers. Writing the actual project proposal would need feedback from the regional groups in terms of persons to be involved and expenses. A few persons would work on the phase-I study design and guidelines. Others would work on 'homework' tasks, including spade-work in various localities.

Naming the collective – Jeeva

Towards the end of the meeting the participants felt we just had to choose a name for our effort! A few names were thought of and discussed...

→ *apara... the sanskrit and scholarly Hindi word for placenta*

→ *aaval... the common Hindi word for placenta in much of central and north India*

→ *phool... meaning 'flower', commonly used for the placenta in various Hindi-speaking regions*

→ *maya... a word used for placenta in Telugu*

→ *jeeva*... a word meaning 'life force' or 'living being' in various Indian languages.

We settled on 'Jeeva'. In Hindi and other north-Indian languages/scripts it will usually be spelled and pronounced 'Jeev'. In the southern Indian languages the word is well understood, too (while 'phool' isn't). Also, Jeeva is a woman's name in that region.

So, 'Jeeva' has been born and named!

Responsibilities and commitments

The following commitments were made by participants (in alphabetical order):

Anu	• spade-work in Dewas city and 2 blocks; • informing others in Madhya Pradesh region to help consolidate the initiative.
Chhaya	• spade-work in Seemapuri re-settlement colony of Delhi (with Sathya's help)
Devika	• spade-work/documentation: Saharsa Dt (Bihar), Pakur / Sahebganj (Jharkhand)
Janet	• culling of information from the Matrika research data (with Deepti Priya) • finalising 'concept note' for funding, and elaboration of the proposal (with Mira) • working out the draft guidelines for field documentation (with Sathya, Mira) • coordinating the historiography aspect
Lalita	• documentation among Barela & Bhilala groups (at home) in Badwani Dt. (MP)
Lindsay	• documentation in 2 blocks of Bokaro Dt (Jharkhand) with 'jaankar dais, budhis'
Mira	• co-ordinating the overall effort • circulating this report by 10th April • initiating probes for funding • organising the Maharashtra initiative • documenting in some Maharashtra Districts (Pune, Nandurbar & Nasik)
(Rashida)	• (left meeting early due to ill health)
Sathyamala	• critiquing concept note / draft proposal • helping (Mira) with co-ordination and trouble-shooting • participating in the study design • support to Chhaya in Seemapuri
Satyalakshmi	• exploring bio-physiology (with CDFD, IICT); also cultural interface (with Janet) • contact with persons in AP to bring together the Andhra regional initiative
Shashi	• initiate dialogue with groups through Sahyogini (Madhya Pradesh) in co-ordination with Anu, Rinchin, etc.
(Shobha)	• (left early to catch train; requested to facilitate the Gujarat initiative)
Sulochana	• documentation in Maval Taluka, Pune Dt (Maharashtra) among Dhangar (shepherd) & Thakar (tribal) people.

- - - - - - -