Chapter 15
Giving Birth at Home in Resource-Scarce Regions of India: An Argument for Making the Women-Centric Approach of the Traditional Dais Sustainable

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15.1 Introduction[1]

Globally, India ranks first in the number of births and until recently ranked first in total maternal and neonatal deaths as well (WHO 2015). Institutional births increased across the country after the implementation of Janani Suraksha Yojana (JSY), an Indian government cash transfer scheme that began in 2005. It provides

[1] This paper is based on a project titled The JEEVA Study, "Establishing the Scope and Pattern of Care by Dais during and after Childbirth in Four Cultural and Geographic Settings in India." This study was carried out between 2011–2015 with a focus on the multiple roles of dais in childbirth and their working linkages with Health Providers (PI, Dr. Mira Sadgopal; co-researchers, Prof. Imrana Qadeer, Dr. Janet Chawla, Dr. Leila V Caleb, Dr. Anuradha Singh, Sandhya Gautam and Dr. Bijoya Roy).

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pregnant women with cash in exchange for documented antenatal care visits and delivery at accredited health facilities. The policy focus on increased institutional births did not truly address the quality of care at these health facilities, their ability to provide emergency obstetric and essential medicines or technologies for that care, the increased workload for the providers at the facilities, and the treatment marginalized women face at these facilities. By policy fiat, the Indian government projected institutional births as safer than homebirths, despite the evidence that facility-based care was often of very poor quality (Jefferey and Jefferey 2008, 2010; George 2007; Iyer et al. 2016). In recent decades, traditional birth attendants or *dais*[2] have been marginalized in maternity care policy, and the value of the maternal and neonatal care that dais provide during labor, delivery, and the postpartum period has been underappreciated (Qadeer et al. 2015; Sadgopal 2009).

Despite their marginalization, dais continue to assist in homebirths in large tracts of the low-resource areas of the country, such as the rural areas and urban slums. Studies of dais' knowledges or skills have tended to focus on either rural or urban low-income and marginalized communities (Bhattacharya et al. 2016; Devasenapathy et al. 2014; Iyengar et al. 2008; Pinto 2008; Chawla 2006). These studies examine why poor women prefer homebirths as well how dais embody familiarity, respect, and rapport with marginalized women who are often subjected to disrespect or discrimination at facilities (Chawla 2006; Pinto 2006). Georges and Daellenbach (2019) refer to the cultural rapport between dais and mothers as "cultural safety" and see it as a source of strength for poor women. Other scholars have argued that dais bring women comfort, a sense of empowerment over their bodies, and agency during the labor process (Qadeer et al. 2015; Sadgopal 2009). This chapter examines how dais' traditional knowledges and practices can manage low-risk births while empowering low-income women during labor and delivery. We show why many Indian women still choose dais in rural areas with poor infrastructure and low quality of facility-based care.

15.2 Methods and Study Areas

Our study was conducted in marginalized communities of Himachal Pradesh (HP), Jharkhand (JH), Maharashtra (MH), and Karnataka (KR). In each region where our partner NGO was already working, we chose 5–35 relatively contiguous villages.

[2] We use the term "traditional dai" and argue that they "represent thousands of years of experience in attending to birthing women and newborn babies in India and south Asia. Surprising to many, the term *dai* arises from British colonial usage, perhaps of Arabic origin" (Van Hollen 2003:39). Dais are not the only "traditional birth attendants" in India, as there is a larger category of women and rarely men, who perform tasks during childbirth and afterwards, in rural and urban settlements. Birth work may be divided between attendance during labor and birth, immediate care of mother and baby, and the ritually polluting postpartum tasks of cord-cutting, cleaning up, and disposing of the placenta (Pinto 2006; Sadgopal 2009).

Ultimately, our study encompassed 56 villages and 6990 households, with a total population of 41,621. We conducted a survey by randomly sampling roughly one-third of the households from each of our four regions. Our retrospective survey (completed in 2013) included 2309 households and 498 live births in the past 2 years. We initially found a total of 261 dais: 108 from MH, 62 from HP, 38 from JK, and 23 from KR. The low numbers in KR and JK may be due to the earlier shift to institutional delivery in KR as well as the remoteness of Adivasi (tribal) villages in those regions. We interviewed 498 women with children under the age of two and a total of 60 dais (the 15 most popular or experienced dais in each of our four regions). Our team of researchers[3] conducted participant observation of the dais and collected retrospective survey data in the local languages (MH: Mainly Pawra, Bhili and Marathi; HP: Hindi and Pahari; JH: Hindi and Bengali; KR: Kannada). We asked informants for informed consent and explained that they were not required to participate nor answer all questions.

Most of the families in our survey performed agricultural work, although lack of land, seasonal weather challenges, and inadequate income led to annual out-migration for farm or construction work within or outside the state. Women worked hard in the fields and at home, fetching water, fuel, and fodder, cooking, cleaning, and caring for children or the ill. One woman in Maharashtra voiced women's everyday hardships, echoing many of our interviews:

> I wake up early morning near about 5, then clean the house, the cattle-house, give the previous night's food to my children, and prepare hot water for my husband's bath. Thereafter I drink black tea and go to our farmland. I come back around 1:00 PM from there and then I prepare food for everybody in our home…..at the end I will eat. In November, my husband will migrate and I will stay here to look after land- and farm-related work …..Women during pregnancy also go with their husbands for labor work. This is the question of our survival.

In all four regions, the public healthcare systems had inadequate maternity services. We found deserted Community Health Centres (CHCs) and first referral units (FRU), nonfunctional clinics, as well as vacant paramedical staff and absent physicians. In Jharkhand, ANMs (Auxiliary Nurse-Midwives) and ASHAs (Accredited Social Health Activists) did not reach out to the most marginalized Dalit or Dom[4] communities. Discrimination against and neglect of marginalized communities within the public healthcare system are also reported in other states like Gujrat and Uttar Pradesh (Iyer et al. 2016; Jeffery and Jeffery 2008).

[3] Research teams in HP: Asha Bharti and Sangeeta Maurya, Kusum and Shanta and (Late) Khajana Ram and Kokila. JH: Neha Srivastava, Anita and Chandana and Yamuna and Tumpa Mudi. KR: Annapoorna and Savitri, Sunanda and Yashoda, and Mrusiddamma and Suprita. MH: Sneha Makkad, Munni, and Ismal and Roop Singh Pavra. Regional partners: (1) Jan Chetna Manch, Bokaro in Bokaro District of Jharkhand, (2) Janarth Adivasi Vikas Sanstha in Nandurbar district of Maharashtra, (3) Society for Rural Development and Action in Kangra/Mandi district of Himachal Pradesh, and (4) Mahila Samakhya Karnataka in Bellary district of that State.

[4] Dalits include several castes and Dom is one among them.

In all four regions, roads to referral centers were often in poor condition and providers in remote Primary Health Centres (PHC) or Community Health Centres (CHC) were not equipped to address complications or even to arrange for immediate safe transport of women to better institutions. Many remote PHCs had only two to three providers, and many lacked the required medicines such as antibiotics, anticonvulsants, uterotonic drugs, or the necessary skills to conduct manual removal of the placenta, vacuum or manual removal of retained products of conception, assisted delivery (forceps or vacuum extraction), and neonatal resuscitation. The CHCs that were expected to provide Comprehensive EmOc (emergency obstetric care) rarely had facilities for cesarean sections or blood transfusions and often could barely provide basic EmOC. Even the secondary level maternity services at the district hospitals in our study regions lacked healthcare providers such as obstetricians and anesthesiologists and essential medicines for EmOC, as well as transfusion technologies, adequate laboratory facilities, or instruments needed for routine or emergency obstetric care such as neonatal laryngoscopes, vacuum extractors, and ultrasound machines (WHO 2009).

15.3 Mother's Attitudes Towards Homebirths

Within our survey population, 66% of births took place at home. We will show why women chose to give birth at home and how the dais have been accepted and respected within these low-resource settings. We will show how dais handle low risk or "normal" deliveries by providing a set of supportive services that are low-cost, appreciated, and flexibly appropriate for the context.

Many of our interlocutors explained that they preferred to deliver at home because of *apana pan* (familiarity and belonging) by which they meant the supportive environment of caring home helpers. Unfamiliar and distant hospitals lack this important emotional, social, and physical support. Women feared the hospital environment, as well as the *chid-phad* (surgical procedures) routinely performed on birthing women such as painful episiotomies, cesarean sections, and tubal ligations. In contrast, dais were trusted, regardless of whether or not they were close relatives or familiar faces.

Women described how dais considered labor pain as a natural process and waited patiently for babies to be born, rather than seeking to intervene or hasten labor as is common at facilities. They felt the dais helped women to gain strength and prepare them for birthing, while guiding them in breathing to help them to relax or feel less fear. All of the women we interviewed were given instructions by their dai about abdominal breathing during labor, and many were told that short breaths and forceful exhalations will help the baby move down the birth canal. Women repeatedly mentioned that the assistance they received from dais and family members made them feel both safe and secure. This warmth and safety acted as a source of power, while facility-based births made them feel lonely, alienated, and isolated. The dai's reassuring touch, confidence-building conversation, and the constant presence of

family helped them do their best during labor and delivery. Their husbands called the dais and helped out by heating water and if required called other knowledgeable women and arranged transport if necessary.

Women appreciated that dais supported both mother and newborn after birth. The postpartum continuity in care helps to restore woman's psychological, emotional, physical, and social well-being. After the placenta (*sui/aawal)* is expelled, dais help cut the umbilical cord (*naal)* and clean up both baby and mother. They advise post-birthing women to eat light foods and also to drink *jhol—a* yoghurt drink—and rice water) for the next few months. They advise women not to carry heavy goods after birth to prevent uterine prolapse and to protect the mother's pelvic floor.

Many women and dais reported regular visits by the dais on the first, third, and seventh days after birth and further visits up to 2–3 weeks depending upon region and tradition. In Himachal Pradesh and Maharashtra, dais would visit on the third day after birth, while in Jharkhand dais came almost twice a day; in Karnataka the dais visited less often. They checked both mother and newborn and inquired if there was any problem with either. Women with less breast milk are advised to take a drink called *peuva* made with one handful of rice and one glass of milk with a pinch of salt. Dai also provide *sek* (dry fomentation) and *tel-maalish* (oil massage) to both the child and the mother. Dais in Karnataka prepared dry packs with dry *neem* leaves, *lassan* (garlic) peels, *ajowan* (carom seeds), and *raagi* (finger millet) and applied these around the woman's belly to give strength to the body, for cleansing and to prevent women from getting sepsis. Dais also provided vaginal fumigation to help speed the healing of minor tears or infections. One of the dai describes this process:

> To give *dhuna sek* (dry smoke from burning incense*)*, first I ask the *puvaati* to hold her *sari* up and sit on the cot. I take a piece of cloth and put some burning coals on that and put some *dhuna* (incense) on this fire, I put this just below her cot. This *dhuna* directly goes to the puvaati's *asthaan/yoni* (perineum) and she gets cured.

Dais believe that *dhuna sek* helps to heal minor tears or infections, and they also help mothers by washing clothes, cleaning the birth room, and offering incense to purify both mother and newborn. These processes restore the mother and integrate the newborn into everyday mundane life and social relations.

15.4 Dais' Skills in Normal Births

Dais' narratives reiterate and amplify the mother's reasons for wanting homebirths. Nearly all the dais expressed explicit support for homebirths and saw their work as far more than a source of livelihood. For the dais we interviewed, work is a social responsibility, a spiritual act, and *dharam ka kaam* (righteous work). As a dai from Himachal Pradesh explained, this work allows them to do "good deeds for others' well-being." They are keen to attend birthing women when called and stay until the

entire birthing process is completed. The dais do not fear traveling long distances alone or at night, even if the road conditions are bad and flooding or landslides are common during the monsoon season. As one dai explained, "Sometimes I have to go in the night also, there is no cause for fear. This is our own area and our own people, our relatives, all ours, and then, there are other people along with us, so what is there to be afraid of?"

All dais interviewed expressed their familiarity with their community, and many spoke of how this comforts and empowers them during the birth process. They have the trust of local people, unlike the providers at government facilities who are often from outside the region and may be responsible for abusive or disrespectful behavior. The dais do not discriminate nor target cases based on their existing relationship with the families. According to one dai, they visit houses "whether it is a relative or enemy." Birth is a sacred time when mundane relationships are suspended.

A dai's knowledge is shaped by her material and social context. She is trained by a mentor who can be a mother, mother-in-law, or a senior dai, and her experience of helping women generates a relationship of interdependence with the community. Unlike the practices of "skilled birth attendants," as defined by the WHO, dais' practices cannot be defined as a set of technical skills acquired through training. Our interviews with dais indicate that most learned their skills as apprentices from a very young age, by accompanying and closely observing their mentors. They were slowly introduced to small tasks such as heating water and cleaning the birth space, but over time their mentors began to ask them to give oil massage or offer physical support to mothers to help with labor pain. Most of the dais started practicing independently only after getting married and having babies themselves, slowly gaining community recognition as they demonstrated their abilities. Their training derives largely from oral tradition and experiential learning (Jordan 1993; Davis-Floyd and Davis 1996), in which emphasis is laid on how to use their senses and hands to understand what is happening in a birthing woman's body.

Dais are called as soon as labor pains start and will provide or arrange for basic materials (hot water, clean cloths, razor blade, thread, etc.) and help the woman in labor by talking encouragingly, telling jokes and giving her back and abdominal massages in order to assess the position and descent of the baby. They also encourage mothers to walk in early labor and help them conserve energy by showing them how to breathe; these services resemble doula work in high-resource settings. Light food and fluids are given to the laboring woman to keep up her strength, including herbal decoctions, hot tea, rice starch, or gruel. It is not uncommon for dais to open up or loosen threads, buttons, clothes, and jewelry or to untie a woman's *guth* (hair braid)—believed to help her relax. By performing these actions, dais monitor the progress of labor, help the mothers gain confidence in their bodies and labor, and facilitate their mental and physical preparation for birth.

In response, women tolerate pain, loosen and warm up, and ease into the final stages of labor and delivery. Some of the Maharashtra dais were inclined to normalize labor pain by seeing births and labor pain as unremarkable events within mundane life. In contrast, the dais in Himachal Pradesh and Karnataka verbally guide women on how to endure pain, by explaining how labor pain differs from other

kinds of bodily pain. They explain that early labor pains are mild with longer intervals between contractions and that the body can be looser at this time. They see progress when the birthing woman's face becomes red, she sweats, and her body becomes tighter. Only late in labor do dais urge women to push; they understand the danger of pushing before full cervical dilation that can lead to a swollen cervix (Jordan 1993). Several dais explained that the degree of pain a woman feels helps coordinate her labor and helps them know when to signal a woman or push (or "give pain"). As one dai explained:

> Labor pain comes on its own. When baby pushes, at that time we say, "give pain." We say when there is slight pain, do not give pain. We tell woman to give pain when there is heavy/strong pain. When there is *prasoota* pain [pushing contractions], the woman starts to sweat. But even then we do not ask to give pain continuously. We should not ask her to give pain forcefully as the woman herself is suffering and then giving pains forcefully causes difficulty. If some women get strong pains then there is no time even to look at the *raasta* [vaginal opening], she should just be made to sit for *prasoota* [delivery] to happen. In some women, if there is time for *prasoota* to happen then we do check the raasta also.

All dais described the bodily changes that accompany the process of labor. An elderly dai explained the shift that happens just before delivery:

> According to dais, when woman is about to become *prasoota* [give birth] then the baby comes down to the lower abdomen and the space on the upper side becomes empty. During the time of *prasoota*, the abdomen becomes tight as a rock. If a woman does not give pain in a timely fashion, the baby stays inside and then the woman has more difficulty. We keep telling the woman to give pain when it is strong. As the woman gives pain, the baby keeps coming out.

The dais' physical assessments of labor progress, their observational skills, and their detection of early signs of fetal distress are individualized to the mother at hand. They allow time to flow as needed. Several dais confirmed that the lithotomy position was rarely used. As one dai stated:

> We do not do deliveries like a doctor…we make the woman kneel down on the floor, place the palms on the floor and apply all the weight on the hands and knees (*mundi*) and do birthing….The way doctor do *prasoota*, the woman does not get pain properly. The way we follow for prasoota, the woman pushes properly.

This hand-and-knee position for birth is well-known across many midwifery traditions, including Guatemala, where Ina May Gaskin first encountered it before making it central to her teaching and writing. It has been proven to expand the pelvic outlet by 2–3 cm, thereby greatly facilitating women's ability to give birth. Thus, it is widely recommended across the globe for breech births, shoulder dystocia, and other complications (Daviss and Bisits 2021). The dais' use of this hand-and- knee position indicates their deep awareness of the normal physiology of labor. In contrast, the lithotomy position used in most Indian facilities (as elsewhere in the globe) has been proven to be one of the worst possible birth positions, as it narrows the pelvic outlet, works against gravity, and inhibits the mother's ability to push effectively. Because many Indian medical staff who work in first referral units do not guide labor using the WHO recommended partograph, their ability to detect symptoms of distress is somewhat arbitrary and depends on staff experience, quality of

care, patient load, and regularity of monitoring. The dai's monitoring of labor is more woman-centered, more pelvic friendly, more experience-based, and thus more sustainable than the poor quality of obstetric care that is delivered in many first referral units in our regions of study.

15.5 Birth Patterns and Complications

In all four regions, most rural households depended largely on dais for childbirth. Roughly two-thirds of all births took place at home, and between 70% and 90% of homebirths were conducted by dais. Government-employed midwives and other "skilled" providers with officially recognized training assisted at less than 10% of the births. In Karnataka and Jharkhand, there is a sharp shift towards institutional births, especially among women under the age of 25 (Table 15.1).[5]

Of the 329 homebirths in our survey, 69% of births were reported as normal, while the remaining third had some complications. Women from the Maharashtra site reported the most complications. We explored these difficult births to better understand how dais resolve complications and how they advise women on when to transfer to a facility.

According to our survey (Table 15.2), prolonged labor, delayed placental delivery, and premature labor were the three most common complications that dais handled. Even when dais recommended transfer, mothers were often reluctant to go to facilities, especially if they were at an advanced stage of labor or had delivered but

Table 15.1 Place of birth in retrospective survey

	Place of birth						
	At home		In hospital		On way		
Study site[a]	No.	%	No.	%	No.	%	Total births
HP	77	74	24	23	3	2.9	104
Jh	75	66.3	38	33.6	0	0	113
Kr	20	20.4	77	78.5	1	1	98
Mh	157	86.2	21	11.5	4	2.2	182
Total	329	66.2	160	32.2	8	1.6	497

Source: Singh et al. (2016)

[a]Himachal Pradesh (HP), District and Block, Kangra (Baijnath) and Mandi (Darang); Jharkhand (Jh), District and Block, Bokaro (Chandan Kiyari); Karnataka (Kr), District and Block, Bellary (Kudligi); Maharashtra (Mh), District and Block, Nandurbar (Dhadgaon)

[5] Sharp shift towards institutional births in KR and Jharkhand: one of the main focuses of the National (Rural) Health Mission (2005) was to increase institutional births, since it was a key indicator to assess the performance of the health workers and of the health institution in Jharkhand. Karnataka's aggressive approach against traditional birth attendants and private informal practitioners/Rural Medical Practitioners stopped them from attending childbirth. Also homebirths made it difficult to get a birth certificate and the entitlements under various government sponsored schemes.

Table 15.2 Classification of birth complications in retrospective survey. Source: Survey data, Prepared by Imrana Qadeer and Bijoya Roy. Adapted from Singh et al. (forthcoming) The Role of Indigenous Midwives (DAIS) in the Health and Wellbeing of Birthing Women and Newborns in Four Diverse and Remote Locations in India, The Jeeva Project Study Report

	Births (4) at study sites				
Homebirths	HP	JH	Kr	MH	Total births
Total homebirths	77	75	20	157	329
Normal births	59 (77)	57 (76)	17 (85)	94 (60)	197 (69)
Complicated births	18 (23)	18 (24)	3 (15)	63 (40)	102 (31)
Excessive delays in labor	2	10	–	9	21
Delayed placental delivery	1	2	1	16	20
Footling or frank breech	–	–	–	2	2
Nuchal cord or cord prolapse	–	–	1	–	1
Frank, footling breech	1	–	–	–	1
Delayed placental delivery and cord issues	1	–	–	–	1
Premature labor	–	2		3	5

not yet expelled the placenta. According to the dais, the most likely reasons for labor delay are poor nutrition and the hard physical work that women continue to perform all through pregnancy. There is no system of formal help for homebirths nor transport in case of complications. Dais were not supported by providers at referral units or by the government health systems. They were only expected to bring women to facilities, regardless of the quality of service, and largely ignored after arrival.

Although dais base their assessments on experience of both normal and complicated deliveries, mothers may ignore their recommendations to go to a facility. In such cases, dais have little choice but to handle complications at home, even as they tend not to intervene without good reason. As such, dais have the ability to stretch beyond strict obstetric norms and thereby "normalize uniqueness" in individual labor situations (Davis-Floyd and Davis 2018). All of the 60 dais interviewed could monitor and assess the baby's position in labor and 80% of them could assess cervical dilation manually (Table 15.3).

Most of the dais we interviewed checked the amount of bleeding postpartum and had an ability to recognize "too much bleeding." They counted and looked at the cloths mothers used as pads to assess the rate of bleeding. We only heard of two very experienced dais who knew how to manually remove the placenta (one was interviewed). Most dais used a combination of putting their hands into the vagina to pull out the placenta, using massage, external manual manipulation, healing herbs, and rituals to help expel the placenta and ensure that all placental clots or fragments were removed. If all else failed, they referred women to institutions.

Dais cut the umbilical cord only after the placenta was expelled and the baby was observed to be doing well. They understood the critical connection between placenta, umbilical cord, and newborn and knew how to "milk the cord" or massage the placenta to revive the baby if needed, using heated bricks or stones. Many of these midwives understood that the baby's life force or breath (*jeeva*) resided in the placenta and spoke of treating a weak or severely compromised newborn by milking the cord to draw upon this life force and transfer its energy to "awaken" the newborn.

Table 15.3 Manual techniques dais knew in retrospective survey. Source: survey data prepared by Mira Sadgopal

Sl. No.	Manual techniques	HP	Jh	Kr	Mh	Total of 60 (%)
1	Assessment of baby's position in the womb	15	15	15	15	60 (100)
2	Assessment of dilation (PV)	15	15	13	5	48 (80)
3	Releasing nuchal cord	11	5	8	1	25 (41.6)
4	Post-birth massage and binding the belly	10	15	13	1	39 (65)
5	Placental stimulation	1	10	10	10	31 (51.6)
6	Perineum support and massage	15	7	8	5	35 (58.3)
7	Supporting breech delivery	12	4	3	5	24 (40)
8	External manipulation to correct breech	5	6	1	8	20 (33.3)

In all four regions combined, roughly half of the dais we interviewed spoke of cord stimulation to revive a struggling newborn that was blue, limp, or unresponsive. Other methods used to revive newborns included blowing in the baby's ear or mouth; splashing the baby with water; beating a plate or drum with a stick to produce sound and vibration; gentle slaps, especially on the newborn's feet; massage; turning the baby upside down; and checking to see that that the airways and mouth were clear. The dais understood that manual resuscitation might be necessary if the newborn had experienced a difficult labor or delivery, cord pressure or prolapse, nuchal cord (around the neck), or placental placement (such as placenta previa) that kept "breath" from reaching the newborn. Many of our mothers spoke of dais who could stimulate and revive unresponsive newborns.

In all four regions, dais explained that they would manually assess fetal position after the start of labor. Roughly 40% of the dais we interviewed had handled breech births, and 41% could remove a nuchal cord (wrapped around a baby's neck). They reported successful breech deliveries during which they had to remove a nuchal cord while the head was in the birth canal. The procedure was described as a delicate one requiring patience, first slowly loosening the cord with a finger if the dai felt it was hindering the delivery. Birma,[6] a dai from JH, describes a breech birth as follows:

> Difficulty happens when baby is *ulta* (breech) because water gets filled in baby's nose and mouth. I insert my fingers and then search for baby's face and lips. When I find it then I press it towards the body and then take out the baby holding it with the other hand.

Like the hand-and-knee position, this kind of head flexion is an evidence-based practice, as is delayed cord-cutting. The following quotation from a mother illustrates how a dai helped in removing a nuchal cord *after* the head was delivered:

> The naal was stuck around my baby's neck. The dai gently put in her fingers and loosened it before she took out the naal from around her neck. The baby cried immediately after the cord came out. My placenta was also not coming out. Then the dai massaged my abdomen. She gently shook the placenta and thereafter she took it out by putting her hand inside.

[6] Names and identifying details of dais have been changed.

15.6 Newborn Care and Birth Rituals

Dais cared for newborns as much as for birthing women. They explained their newborn care in order of priority and need:

> After birth the baby is wrapped in a cloth….The cord is cut only after the *sui* (placenta) comes out and baby is carried in the arms. It is important to put the babies to breast after cutting the cord, otherwise baby forgets to suckle. The first milk is important as it has a lot of advantages for the baby.

Dais were conscious of the nutritious value of colostrum and other aspects of newborn care. They taught mothers how to hold newborns while bathing them and how to massage them with oil twice a day so that their newborns would get proper sleep. They also told the mothers to feed the baby while sitting down, not while lying down, so that newborns don't suffocate. Dais also asked mothers to check the baby's breathing after the baby falls asleep.

Rituals are integral parts of labor and delivery, and there are common features across the four regions despite great diversity in cultures and environments. The common rituals that dais perform include unbraiding hair, removing jewelry, and opening of doors and locks. These rituals serve the symbolic purpose of moving women from the identity of a bound and obedient daughter-in-law—the space of "culture"—into unbound, open, fertile, and strong birth givers, the space of "nature" (Chawla 2014).

Mothers are considered ritually polluted during labor, delivery, and the postpartum period until they are ritually initiated back into mundane life (Pinto 2008; Chawla 2006). The dais, who themselves are considered polluted in this period, help clean the lower body parts of the woman after delivery, cut the umbilical cord,[7] clean away the blood and other bodily effluents from birth, bury the placenta, help the woman and newborn to have their first bath after a few days, and give them both an oil massage. Postpartum rites conducted by the dais mark the end of the "pollution" period and ritually transfer women from pollution to purity. Until the postpartum rites, the mother and the newborn are isolated from outsiders in order to protect them from the "evil eye" or malevolent spirits and harmful energies that could provoke illness or misfortune. The rituals protect the mother/newborn dyad and produce ritual purity that allows them to re-enter sociality.

The ritual burial of the placenta indicates a deep respect for the placenta and its role in the newborn's development. Care is taken to protect the buried placenta from being eaten by animals or taken by another person for black magic. The following quotes express some traditional beliefs:

[7] In the KR site, dais and women reported the use of a new blade for cord-cutting; in JH dais reported using a blade and heating/burning it in fire before cutting the cord; Ii KR, coconut oil and/or turmeric powder were used on the cord stump; in JH they used mustard oil or a white powder they get from hospital) on the cord stump.

> *Sui* [placenta] is inside the *bachchedaani* [uterus] and baby is inside the placenta. While cutting the cord if it is not tied, baby can die. Baby's saans [breath/life] is in that placenta. Baby gets strength and is nurtured through the placenta. (HP)

> In the *naadu* [cord] and placenta is the space for life/breathing. . . the placenta and cord work to give breath/life to the baby. The baby takes food from the placenta. That's why it is *jeev* [life force]. (HP)

> Baby's life is in the *phool* [placenta] only. That's why after being born if the baby does not cry then I milk the *naal* [cord] and bring it towards the baby and then baby starts crying. (JH)

Rituals surrounding the birth contribute to improving well-being and releasing anxiety for the mother, her family, and the wider community. The rituals comfort and support the birthing woman, and collectively they bind families to their communities and emphasize the sacredness of a new human life. Paradoxically, birth is considered both auspicious and polluting for the family and the community. It is the dai who orchestrates the ritual practices while also serving as skilled midwife in her community. If dais were to be formally recognized for their services to women and their communities, their status elevation could serve as a critical social intervention to tackle the pervasive caste and gender bias that undermines their livelihoods and social roles.

15.7 Conclusion

We argue that the skills of dais should be recognized and that they should be treated as the *traditionally skilled birth care providers that they are.* Such recognition would include them as official partners in India's formal maternity care system, dramatically increase the numbers of birth providers in rural India, and help facilitate the connection between homebirths and transport to government hospitals or private facilities. This would also allow them to stay in the hospital with women they have transported, provide continuity of care, and alleviate women's fears of birthing in these unfamiliar facilities. Integration of dais into government facilities might help increase women's willingness to use facilities for birth in emergency situations and erode the pervasive bias against marginalized groups such as Adivasi (tribal), Dalit, and low-income women.

Apart from their skills, dais are effective because they share the culture, language, and social background of their clients, thereby providing a network of "cultural safety." Our narratives show that dais do not rush women through labor; nor do they push women into an artificial time frame set by obstetric standards that may bear little relation to local cultural practices (Davis-Floyd and Cheyney 2019; Buffington et al. 2021). Our data on birth patterns and complications provides evidence of key skills that dais use to manage minor intrapartum and postpartum complications at home. They continuously assess the progress of labor and know when to recommend transfer, even if that recommendation is not always followed. Many

of their practices challenge and contradict the norms of the obstetric model of birth that are followed in most Indian hospitals and clinics.

Our interlocutors noted that while dais are not equipped to handle severe emergencies at home, they do accompany women to hospitals or clinics. If they could be able to continue providing labor and delivery care for their clients and postpartum care for mother and newborn at these referral units, there would be better continuity of care between home and hospital (Davis Floyd and Davis 2018, Dunham and Hall this volume).

A global movement for humanized births respects local knowledges, local cultures, and the quality of women's birthing experiences. In this process, the voices and roles of traditional birth attendants and midwives in other parts of the world where they are not government-recognized are needed to underscore how homebirths can be seen within their broader social and cultural context. The most critical lesson the fractured formal healthcare system of India—and other nations—needs to draw from homebirths is the need to develop a women-centric approach towards birthing.

The humanization of birth care has shown that collaboration between midwives and doctors can produce an environment supportive of the normal physiology of labor and improved maternal satisfaction (Buffington et al. 2021; Fujita et al. 2012). Yet traditional midwives will require a formal set of skills in order to be recognized as trained traditional birth attendants. According to WHO, such skills include being able to handle basic emergency obstetric situations including preeclampsia, eclampsia, intra- or postpartum hemorrhage, dysfunctional progress in labor, and manual removal of the placenta or its fragments, but not cesarean section or high-risk neonatal care (WHO 2002). They should have both skills and social competence.

The current debate in India is about who qualifies to become an official skilled birth attendant (SBA). Auxiliary Nurse-Midwives (ANMs) and general nurses who work in labor wards receive some midwifery training, and a proposal to develop full-scale midwifery training programs is being considered. Today in India, the ANMs, who originally were community level workers doing home visits, now work only in FRUs (first referral units) and hospitals, as will this new group of professional midwives if the proposal is adopted. Reid (2012) shows how by the beginning of the twentieth century in Britain the bias against community or lay midwives who had served the poor with very good outcomes produced a push for middle-class government-trained midwives, who soon replaced community midwives. In India today, there is a similar push for training middle-class midwives more formally, although the proposal is still under consideration.

Women depend on dais in rural or marginalized urban areas of India with low-quality facility-based maternity care, little access to transport, and little prenatal care. The sheer number of dais across rural India where they attend many homebirths is testament to their critical roles in their communities. It has long been clear that *women want care in their communities* (Davis-Floyd et al. 2009). Maternity facilities are distant, under-resourced, and overcrowded, while medical staff are overburdened and often underskilled. They need relief to even offer basic services, not to mention the practice of humanized birth care. An awareness of the poor qual-

ity of public healthcare and of the valuable roles of dais in imparting maternity care is necessary to avoid eliminating or side-lining them—thereby leaving no option of community level care. Reports from urban areas show that middle-class Indian women are increasingly employing doulas to provide the kind, compassionate care that dais also provide (Sood 2017). In remote rural areas, government-trained midwives could learn from dais and begin to create partnerships with dais by encouraging low-risk homebirths and thereby eliminating unnecessary hospitalizations. These partnerships could increase the skills of dais, improve maternal and newborn outcomes for homebirths, facilitate referrals to facilities when needed, and prevent unnecessary transport. Almost all dais in our study welcomed additional training and knowledge but were not keen on being treated as inferior and polluted.

Pushing low-risk births to poorly managed first referral units increases the burden on both institutions and on families who cannot afford costly transport or the risks of poor maternity care. This situation is complicated by well-documented disrespectful, even abusive, attitudes towards women during facility-based maternity care in India (Vishvanathan and Walia 2015; Iyengar et al. 2009). The challenges include (1) improving maternity care at the existing first referral units of primary care for primigravidas, high-risk, and/or medically complicated pregnancies and assuring the availability of transportation from home to first level referral units and/or to hospitals and (2) acknowledging the persistence of the present system of homebirths with the support of skilled dais in low-resource areas, where families frequently choose dais' skills and humanized approach over undependable existing facilities. There is a need to accept homebirths attended by dais as part of primary level maternity care, to recognize dais' knowledge and skills as essential resources, and to encourage and include them in providing antenatal and postpartum care—through need-based, well-conceived participatory trainings if necessary. With health budgets dropping in India, we argue that the formal incorporation of dais into the Indian maternity care system is the best path to strengthen Comprehensive EmOC in resource-scarce areas and to create a viable and sustainable maternity care system in that country.

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