

A tale of two births
By Thingnam Anjulika Samom

Giving birth with the help of a skilled attendant is seen as the ideal but it is far from the reality for millions of women.

[Panos Features] Salabila Camp in Assam's Bongaigaon district is a cluster of straw and bamboo huts on a community grazing ground, guarded by an imposing iron gate and a dozen security staff. Women in faded saris are setting up new dwellings, and men stroke their beards and crowd around the camp's tea shop.

Salabila Camp is home to around 8,000 people, Muslims who were displaced from their villages along the Indo-Bhutan border in the early 1990s by the ethnic cleansing programme of the Bodo community. Many are struggling to get two meals a day, and a meaningful existence. After five years' stay in army camps, they were moved to a "rehabilitation" camp at Goraimari beside a national highway, only to be shifted again to Salabila because the highway was being extended.

It is here that I met 25-year-old Saleha Khaton, mother of three children. Her two-month-old baby son Parul lies on a piece of cloth spread over a plastic sack on the ground. Keeping watch is Parul's maternal grandmother, 47-year-old Amina, and Saleha's two other children play near her outstretched legs. Saleha's husband Afazuddin, works on a nearby road construction project with an income of Rs.66 a day (just over one US dollar).

Parul was born in their previous camp at Goraimari, about half an hour's drive away. He was delivered on a straw bed spread on the floor of the one-room straw hut, shortly after his mother had finished cooking and feeding her two children, husband and mother.

The labour pains had already started, so soon after serving dinner Saleha asked her mother to fetch the dai, or traditional birth attendant, 40-year old Ayesha Khaton. The nearest health centre to Goraimari camp is eight kilometres away. It was too far, and she knew she could not have her child in a health centre with a trained midwife and doctors on hand. She had to depend on the dai, as with her previous two deliveries.

Women in the nearby huts brought hot water, and a new shaving blade. "When the dai came I was already lying down on the straw bed as the pain had increased a lot. I don't recall how long the labour was," says Saleha, "She checked my condition and then she dipped some clean linen into the hot water and laid it on my vagina to loosen the muscles. After a while she told me to push and so I pushed."

In the Salabila camp too, Saleha finds it hard to get healthcare, "There is a health centre about a kilometre away in Dumpara village but the local Rajbongshi people who are objecting to our stay here, pelt stones and bottles, and pick quarrels with us. So we don't like going there," she says.

In a small pukka house in the heart of Imphal town, the capital of the state of Manipur, Maisnam Chaoba lies next to her 22-day-old daughter Thoi Thoi, amid stacks of freshly washed linen. A meiphu full of red hot charcoal stands next to her bed keeping away the early spring chill.

Chaoba belongs to a middle-class family, and she had planned her delivery. "My doctor had already told me on my last visit that it would be a Caesarean birth, and since I had already been under the scalpel twice I wasn't afraid at all," she confides.

It was Chaoba and her husband Manikchand's first birth after six years of marriage, during which she and he had undergone a string of medical consultations and all possible treatments to have a child. She finally conceived with the help of a doctor at the private Shija Hospitals and Research Institute, one of India's top medical establishments.

In Imphal she has good access to healthcare facilities – both government and private. On the day of the birth at around 9:30 am, after an early lunch, the family – Chaoba, her husband, her younger brother-in-law, and her three sisters-in-law - drove in a hired auto rickshaw to the hospital, 20 minutes' away.

“Inside the operating theatre, the doctors instructed me to breathe deeply. Then they gave me an injection in my back, telling me that my pain would ease in a few moments. I was praying fervently that everything would be all right. Then suddenly I heard them pulling out the baby with a whooshing sound. One doctor said, “She is beautiful; lots of boys will be after her when she grows up.”

Chaoba's experience of childbirth reflects the ideal scenario, agreed worldwide by researchers and health policy makers, for women to give birth in the presence of a skilled birth attendant with the option of medical intervention if complications occur. The Indian government has recently adopted this policy.

But it remains the case that for most deliveries in camps for displaced people and many rural areas it is a dai, like Ayesha Khatoon, who runs the show. “Just push and heave” is the instruction she gave Saleha, advice she herself followed when she gave birth alone to the last of her five children.

It is estimated that women from the poorest economic groups are around eight times less likely to get the help of a trained birth attendant, increasing their risk of complications and death. This is one of the reasons for the high national maternal mortality rate of 407 per 100,000 live births.

“Unsafe deliveries conducted at home by relatives and dai are important causes of maternal mortality.” agrees Dr Leishangthem Menjor, deputy director of the Reproductive and Child Health Department at Manipur State Government's Department of Family Welfare. Ruchira Neog, executive secretary of the Voluntary Health Association of Assam (VHAA), says, “Especially in remote areas, home deliveries are most common. This could be partly due to illiteracy, especially in camps like Salabila, and also because the nearest health centre is either non-functional or too far away.”

In some areas, women or healthcare workers are beginning to get cash incentives if they opt to give birth in a hospital, but for many inaccessible rural areas it is simply not an option.

Cutting the number of women who die in childbirth and from pregnancy and childbirth-related complications is one of the UN's millennium development goals. If progress is to be made, some researchers argue it is vital to improve the environment in which the vast majority of poor women give birth. One option is to train traditional birth attendants like Ayesha Khatoon so that they can spot complications and emergency situations.

A team of researchers headed by Anthony Costello, Professor of International Child Health at University College, London, argue, in the medical journal *The Lancet*, that training traditional birth attendants is a cheap yet effective way to improve maternal survival. “Traditional birth attendants are not a substitute for midwives but they are the main provider of care during delivery for millions of women, especially in settings where mortality rates are high,” they write, adding, “Since 1990 international agencies and academics without robust evidence have persuaded governments to stop training programmes for traditional birth attendants.”

At the Indian government's Reproductive and Child Health Department, training traditional birth attendants has indeed fallen out of fashion. The RCH is now focusing on the training of skilled birth attendants and on birth in hospitals. The advice of Ruchira Neog at the Voluntary Health Association of Assam is clear, “Very often the dai don't know the danger signs. Our emphasis is – have a skilled person.”

But the issue remains that even if health facilities and skilled attendants become more widely accessible, many women would still prefer to give birth at home using a traditional attendant. Some doctors also have sympathy for this view.

Dr Chirom Pritam, Registrar at the Regional Institute of Medical Science (RIMS), the largest such institute in India's north-east, says, "The dai will often be someone you know well. She will come to your place, and over a cup of tea you can ask so many questions, clear all doubts, and get more familiar with her. Everyone prefers a familiar face over an unknown one, and most patients prefer the comfort and familiarity of their own homes over the unfamiliar, cold, sterile institutional beds."