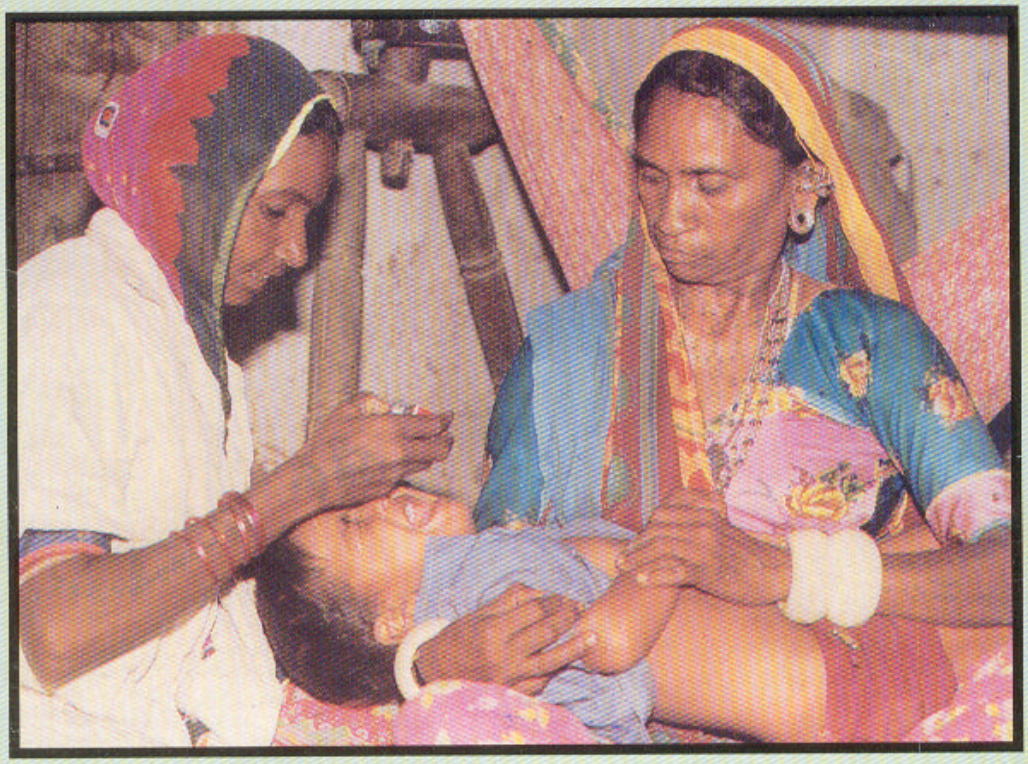
Our Barefoot Doctors : The Midwives of SEWA



JUNE 2000

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June 2000

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Introduction

For the past fifty years, we have been searching for appropriate ways to reach health services to the poorest of families from accessible to the most remote areas of the country. We have experimented with developing a cadre of local barefoot doctors - the village health volunteers scheme, with engaging private doctors, training school teachers and thousands of multipurpose workers including T.B. and malaria workers, But the vexing issue of how to reach basic, life-saving, primary health care with back up referral services to the mass of our people, remains. Meanwhile, the costs of medical care - drugs, consultations, transport and diagnostic tests escalates, putting a huge burden on poor families.

A SEWA, our members are constantly saying that whatever they earn is spent on sickness. In fact, in a longitudinal study of stress events in the lives of 1,400 women, illness was identified as the number one stress factor. Many of SEWA Bank's 125,000 depositors, all poor, self-employed women, take loans to tide themselves or a family member over in times of sickness. Others are unable repay their loans. Or else they go into debt.

SEWA is a trade union of women workers of the unorganised sector registered in 1972. These are workers who form 92% of the Indian work force and yet remain out of the purview of protective labour legislation and benefits such as sick leave and maternity benefits.

SEWA's main goals are to help its members attain full employment and self reliance at the household level. Full employment means such employment that provides women with work and income security, food security and social security (health care, child care, shelter and insurance). Self reliance is a holistic concept, encompassing the economic viability of an activity, as well as decision-making and control by the workers themselves.

Because our members believe that they cannot achieve their full employment without health security, at SEWA we have also been wrestling with the issue of how to reach affordable, appropriate health services to our members and their families, in a manner which is sustainable in the long term.

The Important Role of Dais to Promote

"HEALTH FOR ALL"

In over twenty seven years of organising poor women, including on health issues, what is clear at SEWA is that.

1. Organising the poor into their own organisations, including midwives and health workers' organisations, is the most effective way of reaching health care to the poorest of communities.

2. Midwifery is an important economic activity with tremendous potential in both providing an essential service to women, and at the same time serving as a source of self-employment for dais (traditional midwives). A survey of 101 midwives of Gandhinagar district by SEWA found that 94% were willing to undergo professional training.

   At SEWA, we organise dais and give them skill and knowledge upgradation training according to their needs, through a special school for midwives. The training also includes first aid and primary health care. We have seen that after such training. dais begin to earn between Rs. 51 to Rs. 101 for each birth attended. Of course there are some in the village who cannot afford to pay in full or simply cannot pay at all. Dais, themselves are generally among the poorest in the village, and often accept in kind' payments like foodgrains. In sum, the cash and in kind payment they receive are an important support to dais. Midwifery, therefore is an important source of employment at the village level, with great potential for further development.

3. Dais and local health workers (barefoot) doctors) should be at the centre of all health action, if we are to reach the poorest and weakest within communities - i.e. women and children.

   Consequently, at SEWA we have been organising dais and promoting the formation of their own cooperatives or local associations. Specifically, dais have been running a campaign for their recognition and involvement in all village level health activities, including RCH'.

Dais recommend taht :

1. Identity cards should be issued for all services.
2. They should be central in the RCH programme and all health services.
3. Training should be ongoing and equip midwives with knowledge and skills in midwifery and primary health care.
4. Dais and their organisations (cooperatives, associations) should run the government's maternity scheme.
5. The honorarium currently given to dais (Rs. 10) should be increased to Rs. 25 and this entire fund should be given to dais' organisations for implementation. Dais who refer complicated cases to higher levels of care, should be given Rs. 50 as a referral fee.
6. A complete kit with regular replenishments should be made available to dais.

Dais' Own Organisations

To achieve the above, dais have organised themselves into the following SEWA - promoted organisations :

Midwives & Health Workers' Cooperatives

1. Shri Swashrayi Mahila Lok Swasthya Cooperative Limited - Ahmedaba district & Ahmedabad city
2. Shri Krishna Dayan Cooperative Ltd. - Gandhinagar district
3. Shri Swashrayi Mahila Shramshakti Dayan cooperative Limtied - Kheda district
4. Shri Swashrayi Mahila ShramLaxmi Dayan Cooperative - Mehsana district

RCH : Reproductive and Child Health

Other Local Organisations providing Health Care to SEWA Members

1. Banaskantha DWCRA Mahila Association - Banaskantha District

2. Kutchcraft Association - Kutch District
3. Sabarkantha Khedu Mandal - Sabarkantha District
4. Surendranagar Women and Child Development Mandal - Surendranagar District
5. Sukhi Mahila Mandal - Vadodara District

Organisation for Change

After six years of grassroots organising of dais, struggle and negotiatin with the state health authorities, dais in Gujarat state have moved a step forward.

The turning point came in 1997 when Gujarat's Minister for Health, Shri Ashok Bhatt, organised exhibitions and a mass rally to mobilise all sections of society for safe motherhood. 1,000 dais organised by SEWA from 5 districts attended this event and articulated their recommendations for safe motherhood and safeguarding women and children's health.
The Minister was very sympathetic and promised to give the recognition to dais, that was their due.

On October 2nd, 1998. it was officially announced that dais would be given identify cards, skill upgradation training, enhanced remuneration for deliveries attended and greater recognition for their yeoman services in the state. In fact, dais wow obtain Rs. 20 from the government per normal child birth attended and Rs. 50 for obsteric emergencies referred by them. All of this is a very welcome step in the right direction and SEWA's dais feel encouraged and valued for the first time.

However, as always, the question that remains is how the above policy changes are to be implemented so that they are translated into positive action at the village level.

For the past six years, SEWA has been suggesting that all activities pertaining to dais especially the RCH programme in the state, dais' remuneration and maternity benefits scheme, be handed over to the dais' own organisations (cooperatives or mandals) or local NGOs working actively with dais. In fact, through the joint efforts of GUjarat Voluntary Health Association (GVHA) and several health NGOs in 1997, we managed to obtain a

'Government Resolution' (GR) starting that the issued of dais' remuneration should be handed over to their own cooperatives and NGOs. This would mean that the funds earmarked for dais would reach them through these organisations, rather than the government machinery.

Unfortunately, there has been much resistance to this idea - indeed any attempts to delegate or decentralise health activities with the required resources to dais themselves, is still resisted by some policy makers and administrators.

The main reason for this is a conceptual block : several policy makers are of the, view that dais have very little to offer because dais or 'TBA's, as they are referred to, are illiterate, semi-skilled village workers who resort to unhygienic and unsafe practices. Further, they argue, fifty years of investing in 'TBA's' in India has not shown results. In sum, the feeling is that the institution of dais should be phased out — certainly no new dais should be trained for the villages.

The reality of health care in India and people's, especially poor women's own preferences, reveal a very different picture. Even in Gujarat, commonly considered to be a progressive
state with well developed, modern medical facilites, the vast majority of child births are attended to only by dais. In Ahmedabad city, about 55% of all deliveries are conducted by dais. In rural areas, the figures go upto to 80% and in the remote corners of the state - the desert district of Kutch, Banaskantha and Surendranagar and the eastern tribal belt, the figures are close to 100%. In a survey conducted by SEWA, more than 75% of child deliveries were done by midwives alone. Some are formally trained and some are not. But all are very experienced and trusted by women and their families. They are the doctors of their villages, assisting in child birth, taking care of new borns, often providing other health services and traditional herbal remedies.

They are close to their rural sisters, committed to their well being and always available - round the clock, in rain or shine. Indeed they are a rich resource for poor women who consider them to be skilled, knowledgeable and helpful.

At the same time, these dedicated healers are among the poorest women in their villages. Often widows or destitute, they eke out a living below the poverty line. Many are Harijans, Muslims or from castes of the working poor. They provide their serices free, or at a

token cost, or in exchange for foodgrains or clothing. A socio-economic survey of 101 midwives conducted by SEWA found that 79% of them were illiterate and 60% of them had an average monthly income below Rs. 500 (i.e. they were below the poverty line index).

Several peoples' organisations and NGOs have recognised and respected the services of dais and the huge potential they present as skilled and knowledgeable traditional healers who command the respect and trust of their communities. Consequently, skil upgradation training programmes and efforts to broaden the range of their health knowledge and skills have been undertaken. At the micro level these efforts have shown good results. But perhaps, these have not been documented as widely as they should be and as a consequence, remain as scattered efforts apparently with limited impact.

Recommendations

At SEWA, our experience shows that dais must be the starting point for any health action with women and children. They are ready to organise and many are eager to learn and get access to new knowledge. Based on these experiences, we have a few recommendations :

1. Dais are a rich repository of traditional knowledge and skills in child birth. Many of their preactices are sound, some are not. Dais need exposure to some safe and hygienic practices. They need access to the latest developments in science, specifically in obstetric practice. This new information can reach dais via meetings and training sessions, including exposures to hospital care.

2. Skill upgradation training and the curriculum, needs to be reviewed and where necessary re-developed, keeping in mind dais' level of skills and knowledge. In fact, their existing knowledge base needs to be understood, evaluated and respected. This should be the starting point for all dai training. District-level dai schools should be set up, run jointly by government, NGOs and the dais themselves, Curriculums should incorporate primary health care in addition to midwifery. There should be regular feedback between trainees and trainers based on the dais' everyday experiences. These then should be the basis for ongoing training and "refresher" sessions.

3. Each and every dai should have an identity card. It gives her the visibility and the recognition that is her due. It will also give health planners a readymade list or census of dais in each district. This will greatly facilitate planning and involvement of dais in health services.

4. Organising of dais into their own collectives such as cooperatives, mandals and associations should be actively promoted. These dai organisations should then be delegated responsibility, for example of taking up many of the RCH activities currently planned. This could be done in a phased manner i.e. starting with a few health activities and then extending to others.

5. Financial resources both for the health activities suggested above and dais' own remuneration should be made available to dais' organisations with full decision making powers and accountability to district authorities.

6. Backward and forward linkages in our health system should be strengthened with the help of dais and their active involvement. Also, their linkages with referral services, both government and private should be strengthened. And at the same time, we should build on their existing rapport and relationships with communities to ensure that health services reach women's doorsteps.

7. Documentation should be undertaken of dais' existing skills and practices and approaches to upgrading and strengthening these, as well as "best practices" among dais, their organisations and NGOs working with dais. These should be widely disseminated both among policy-makers and among dais at district-level dai sammelans.

Conclusion

These are a few recommendations for action involving dais. It is our firm belief that it is joint action with dais which will bring health services to the poorest in our villages, especially to women. Indeed they are a rich resource in the health sector. Let us learn from them, recognise their contribution and work with them towards our goal of "Health for All."

SELF EMPLOYED WOMAN'S ASSOCIATION (SEWA)

The Self Employed Women's Association (SEWA) is a Trade union of poor, self-employed women workers, registered in 1972, SEWA members earn a living through their own labour or small businesses. They do not obtain regular salaried employment with welfare benefits, like workers in the organised secton. Of the female labour fore in India, more then 94% are in the unorganised sector. However their works is not counted and hence remains invisible.

SEWA's main goals are to organise women workers for full employment and self reliance, through the twin strategies of struggle and development

SEWA is both an organisation and a movement. The SEWA movement is a confluence of three movements: the labour movement, the co-operative movement and the women's movement. Most importantly. SEWA is a movement that is owned and developed by self employed women so that they may become stronger, more visible and gain due recognition for their tremendous economic and social contributions to the economy and society at large.

SEWA ACADEMY

The SEWA Academy was created in 1991 with the objective of providing the self employed women members of SEWA with training facilities of an international standard in order to build their capacities in the areas of skill development, education and leadership. The Acadermy is the focal point for co-ordinating and implementing SEWA's activies in member education, teaching, research, planning communication, advocacy and evaluatin. SEWA Academy's training programs are tailor made to meet the needs of SEWA members and empower them through increased knowledge and self confidence.