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# Women's birth experiences in Pakistan – the importance of the Dai

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## Abstract

**Aim.** The aim of this paper is to present findings from a research study undertaken to explore women's life and birth experiences in Pakistan.

**Method.** The design was ethnographic (Denzin, 1978) with an anthropological slant. Participant observation was undertaken in a maternity hospital in Pakistan and an over-50s luncheon club in the UK. Following two focus groups, in-depth interviews were undertaken with 16 women. Data were collected from observation, experience gained during nine field trips to Pakistan and the use of a reflective research diary.

**Findings/results.** The main theme that emerged was the importance of the Dai (untrained traditional birth attendant) in women's accounts of their experiences. This theme included her influence on the women's birth experience and her work in the context of relatives and other health professionals. Other sub-themes not covered in this paper were boy preference, the omnipresent medical model, birth systems, the powerful symbolism of blood, purity shame and honour, and specifically from the women interviewed in the UK – coming to England and modernisation.

**Implications.** The Dai was considered essential for the birth and currently 80% of all rural births are attended by Dai. However the medical professionals and policy-makers in Pakistan consider Dai practice to be dangerous and aim to establish systems for supervising and supporting skilled birth attendants, including the development of emergency referral services and a community midwife programme. Further research on women's experiences of birth in the home and hospital in Pakistan are necessary to inform government policy.

**Key words:** Women, birth, Pakistan, Dai (untrained traditional birth attendant/Urdu midwife), ethnography

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## Introduction

*'The physiology of birth is universally the same – yet parturition is accomplished in strikingly different ways by different groups of people'* (Jordan, 1993: 3-4).

Examining the birth experiences of women in Pakistan can shed light on the psychosocial influences on birth globally. In Pakistan, 80% of the births take place at home attended by 'untrained' personnel (NCMH, 2002; Kamal, 2002). Birth in Pakistan is seen as 'women's business' and has not been discussed outside the conclaves of birthing women. Knowledge has been passed on verbally to those who 'have a right to know'. This study gives a glimpse of the rarely seen role of the traditional birth attendant from the eyes of birthing women. It identifies the important role of the elder female relative at home birth – a role that virtually disappeared in the UK with the advent of hospital birth.

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## Literature review

The search strategy initially had two parts – one included a review of women's knowledge, as this was seen to be the reason why so little had been published, because birth was women's business (not covered in the paper). The second part of the search focused upon the health status of women in Pakistan.

This was particularly difficult because statistical estimations were either inadequate or contained serious discrepancies (Shaheed et al, 1995). The lack of reliable information is combined with a cultural reluctance to express need and results in a great deal of suffering and often early death. Life expectancy for men is 57 and for women 57.7 (Pakistan Demographic Survey, 1990-1991). The Pakistan government acknowledges their resource-constrained health services are on the decline (Ashraf, 2002). In 1996, Awan undertook a study of women's health in the suburbs of Lahore and provided evidence of the stark reality underpinning both the mortality and morbidity of childbirth in Pakistan. The World Bank (1993) reported the infant mortality rate to be 103 per 1000 live births. Chawla (2000) questions whether with the current system, any reduction in mortality and morbidity rates is possible 'in the presence of poverty, illiteracy and discrimination'. More than three-quarters of all maternal deaths take place during or soon after childbirth (AbouZahr, 1997). The World Health Organization (WHO) (1997) reported that worldwide only 53% of births are attended by skilled birth attendants and it has recognised that in countries where skilled attendant numbers are low, there are higher rates of maternal death and disability.

Kamal (2000) has campaigned for decades to train traditional birth attendants (Dais), and now (personal contact,

2005) has changed her thinking advocating improved training of midwives especially in the community:

'Professionally competent midwives can bring down the maternal death rate. The evidence exists to show that the countries that have utilised competent midwives to provide maternal health services brought down their maternal death rates much quicker than those who did not.'

Kamal's crusade is hampered by the direct translation of the term 'midwife' as 'Dai'. The common term for the trained midwife and the untrained traditional birth attendant is also 'Dai'. For the purpose of this study, the Dai was understood to be the untrained traditional birth attendant.

Due to a lack of literature on birth in Pakistan, this research has drawn on childbirth writings from India. Jeffery et al (1988) undertook research in the Bijnor district of Western Uttar Pradesh Northern. The research was a survey of women who had recently given birth. The overall aim was to study childbearing as socially-organised phenomena. Throughout the research there was extensive contact with Dais. Jeffery et al's findings (1988) told of Dai practice that could be classified as 'dangerous' when they undertook vaginal examinations without washing their hands; pushed on the woman's belly in labour; wrapped a ball of dry mud in a rag to absorb the postpartum blood; and asked for the dispenser to give injections of oxytocin. Contrary to this, Chawla (2000) studied the indigenous health knowledge systems of Dais in India and found it was the health of the women that directly correlates with poverty and not Dai practice. Chawla (2000) recognised the untrained Dai as being 'with women' and further defined her as a specialist in women's wellbeing describing her work as 'elegantly simple yet effective'. She also found that even the most competent and active Dai did not have an apprentice. This led to the conclusion that 'the tradition of becoming a Dai is dying from neglect'.

Sizoo (1997) explored the life-worlds of 15 women of different ages from a range of cultural, social and geographical backgrounds, from Asia, Africa, Latin America and Europe, their relationships across generations and how women face, negotiate and shape their social space. Sizoo's work showed a way to create living knowledge. Behar (1993) gave non-relatives as family a sociological descriptor of 'fictive kin'. This concept was focused on the importance of female relatives in decision-making and direct care of the woman in labour.

While Jordan's (1993) study of birth in four cultures (US, Sweden, Holland and Yucatan) did not include an Asian country, her work contributed significantly towards the author's understanding of the biosocial framework of birth in the context of her work as a midwife in the UK. Jordan (1993: 3) further observed that within ethnographic records, 'there is no known society whereby birth is considered merely physiological' confirming 'birth is always socially marked and shaped':

'Efforts to reduce the contradictions between childbirth as a medical risk and childbirth as a social celebration have not yet succeeded' (Jordan, 1993: 925).

She also acknowledged the rapid westernisation of the Third World, which is largely responsible for the re-defining

of childbirth as the exclusive domain of professionals trained in mainstream scientific obstetrics. Harding (1996: 341) also confirmed the dangers inherent in the importation of post-industrial western models (of childbirth) into developing countries: 'The importation of Western industrial models into developing countries did not have the intended effect (of enabling societies to catch up). At best they were unsuccessful; at worst they offered advantages to the advantaged and further disadvantaged economically vulnerable people. At times destroying the environment on which daily subsistence developed, so called development was in fact a continuation of imperialism and colonialism 'by other means'.'

### Methodology

Hammersley and Atkinson (1992: 98) define ethnography as a 'blend of techniques that uses a systematic process of observing, detailing, describing, documenting and analysing life-ways'. Data were obtained through life-story in-depth audio-recorded interviews and observations undertaken by the author, a research assistant (retired midwife) and an interpreter. Heidegger (1962) showed that a primary relationship with things (women's birth experiences in Pakistan) is not through discursive knowledge, but through lived experience. All the women had given birth in Pakistan. The author's experience of birth in Pakistan is also a lived experience, albeit as an observer, teacher and culturally 'strange' midwife. Being a mother also led the author to feel a shared bond with the women. Feelings were recorded in a reflective diary, combined with field notes and written in consultation with the retired midwife and interpreter.

The ethnographic life-story provides insights into individuals, not as historical eye witnesses, but as bearers of culture and tradition. As such the ethnographer concentrates upon intensive work with the participants rather than documentary survey or evidence (Thompson, 1996; Dunnaway Baum, 1996). Story-telling is a fundamental form of human communication. Chase (1995) says there are limitless applications of life-story recordings as a research tool. Kirkham (1997) argues that a story tells more than its tale, because it speaks of context and values. Listeners absorb the story through the web of their own experiences and indeed their own stories. Stories are rehearsed and shaped especially for the audience. One would never tell a stranger the intimate details of a birth experience. As researchers the presence, dress, manner, interest, type and sequencing of questions, their own mood and that of the woman, the presence of others, the timing and other factors un-thought of, influenced the shape and content of the story the women told of their lives and particularly their birth experiences. At a different time, place and with a different person, the story would be different. Time was invested in developing a trusting relationship with the women so they would feel safe to tell their birth stories. This was more difficult with the women in Pakistan, as the communication was through an interpreter. The dilemmas of using an interpreter to interview women across a cultural and language barrier have been explored by Chesney (1998; 2000).

The research used a multi-method approach (Denzin and

Lincoln, 1994). The data collection methods used were focus groups, individual interviews and a reflective diary. Objective reality can never be wholly captured, but according to Denzin (1997: 111): 'A combination of empirical strands, perspectives and observers, in a single study adds rigour, breadth and depth.'

The empirical strands that weave together the method for this research arise from, and return to, the women's words. Investigator triangulation was used, the interpreter and retired midwife contributed to the reflective research diary, which may also be classified as field notes. All the data, themes and analysis were read and commented upon by a Pakistani woman.

### **Participants**

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The sampling strategy was a convenience sample using 'informal snowballing', which is considered to be appropriate for accessing stigmatised groups (Ribbens and Edwards, 1998). The decision to use this technique was made after initial contact with potential participants in a north of England town and its twin town in Pakistan. The 'advertising' for recruits was informal and the starting point was by word of mouth, local knowledge and previous contacts. The initial plan was to interview women in Pakistan only; however during the planning of the specific Pakistan field trip to undertake the interviews with women in Pakistan, the aims of research were discussed with a woman who became the gatekeeper to four out of the ten women interviewed in the UK. She had experienced birth in Pakistan and led an Asian women's luncheon club. While being interviewed, she said many women at the club had also had birth experiences in Pakistan and would be happy to talk about them. Thus she facilitated access to this group (17 visits were made to the luncheon club over a period of six months). It is with women from this group that two focus groups were undertaken. The women in Pakistan were accessed through social contacts made on previous working visits to a Red Crescent Maternity Hospital in the Punjab interior.

The women in the UK were closer geographically and thus easier to access, providing the opportunity to return for follow-up interviews and return the transcripts for verification.

There was an age differential between the two groups of women. On average the age of the women interviewed in Pakistan was 42 and in the UK 55. However, it has to be said that age did not appear to be important and estimates were given rather than the actual year of birth. The age of the women linked to the recency of the birth experience.

The strength of the sampling method was in the range of social groups represented, from a cleaner to a professor. A further strength of using two groups of women was the potential to open out the data to linear time by hearing birth experiences across generations. Six of the ten women interviewed in the UK had daughters or daughters-in-laws present and with two women, their granddaughters were also involved in the interviews. A weakness in the sample was the small numbers involved and the limited time to establish a close relationship with the women in Pakistan. Also for the women in the UK, the time that had elapsed

since giving birth may have affected recall. However, according to Simkin (1992) even after a six-year gap, women have vivid 'flashbulb' memories of specific events during labour as well as excellent recall of their labour and birth experiences. Also Robinson (1995) found women have an intensity of recall for birth experiences, which is different from other memories.

### **Ethics**

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Ethical approval to undertake this research was not sought in the formal sense. When the research began in 1997, ethics committees and research governance was relatively underdeveloped and none of the women were accessed through the NHS. Permission was given by both the twinning groups in Pakistan and the UK to undertake the research field trip. Approval for the attendance at the over 50s women's group was gained verbally through the gatekeeper. Although the infrastructure for ethical approval was loose, great care was given to ensure each woman gave informed consent before the interviews took place and a protocol was developed. This protocol involved considering the researcher effect on the data (Chesney, 2001).

One is challenged as a researcher to act as an objective scribe, devoid of influence or judgment to adhere to a strict moral and ethical code, to do no harm. These words have the potential to become protective rhetoric, words that impress the reader. It is only known that there is potential for harm by asking the respondent or her representative. Behar (1993: 13) worried about the 'violence' to the life-story by turning it into a disposable commodity of information. However the question is framed, it is the responsibility of the researcher to protect the women's word. This was undertaken by seeking the advice of members of the community. Both were trained advocates whose sole purpose within the research was to protect the participants. The bare minimum ethical principle stated clearly in the protocol involved respecting the women and their words and treating them with integrity and honesty, accepting the comments of the respondents or their advocate as the final word.

I was constantly aware of other ethnographer's beliefs around the analysis and writing up of research. Behar (1993) found that ethnographers, historians, journalists and fiction writers are all purveyors of a range of 'false documents'. While the thesis would not be all false as in fiction, it could be accepted as valid to have the interpretation of an outsider: 'Telling of ethnographic tales relies on blurred or mixed genres, and makes it increasingly difficult to give a single label to the work. The text we write today partake of a criss crossed genealogy and fluctuating value...they are made in one place to be read in another' (Geertz, 1983: 36).

### **Analysis**

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Analysis of the data began with by applying Alasuutari's (1995) framework for concept analysis. This, like most concept analysis frameworks, involved reading and re-reading the data in totality to identify key concepts. The author was uncomfortable with the metaphors Alasuutari used, 'purification', 'cleansing' and 'unriddling' of the data, a

sense of not valuing the data emerged. This led to further analytical frameworks being applied. These were a hybrid of Polkinghorne (1995) and Childress (1998) frameworks, both specifically designed for ethnographic research and based upon narrative analysis principles. Polkinghorne (1995) recommends asking ontological and epistemological questions of the data and synthesising the context. Childress (1998) defines this as multiple perspective analysis. Questions asked of the text were based upon attending to the embodied knowledge and mindful of influential others, while addressing the central character and attending to the historical continuity with the ultimate generation of a story that is both understandable and plausible (adapted from Polkinghorne 1995: 5-23; Childress, 1998).

This approach analysed the events and happenings (the women's words and the author's experiences) by means of content analysis, reading and re-reading, identifying themes, through narrative and concept analysis, creating new perspectives by asking questions of the data eventually leading to a 'plot' that leads back into collective stories/allegories with meaning. A story was constructed regarding women being disturbed in labour by having a hand on their arm. This 'broke' her control over the pain. Stories involved many central characters (mother-in-law/aunt/doctors). One story demonstrated how the birth environment can disempower the birth attendant. A home-birth was progressing slowly so doctors were summoned, but the woman was too near giving birth to transfer to hospital (the head was delivered). The doctors were given 'first chance' to deliver and 'could do nothing', neither save the baby nor the mother. Eventually the Dai and the woman's mother-in-law successfully delivered the baby by getting the woman to squat on two pillars of bricks and pushing on the woman's stomach.

A psychologically safe environment for practice was also highlighted by Jordan (1993: 149) in her study of birth in four cultures: 'Midwives who in the environment of the hospital-based training courses often appeared stupid, illiterate and inarticulate showed a completely different face when engaged in doing their work in their own communities where their skills were acknowledged and respected.'

When analysing the narrative, it became apparent that the data from the women in the UK were richer in context. Possible explanations for this may include the interviews undertaken in Pakistan were through an interpreter and there was only one meeting for the interview, whereas in the UK, the women had the opportunity to check out through the gatekeeper researcher credentials.

#### **Race as a methodological issue**

Twine and Warren (2000: 13) consider race to be a methodological issue. They used theoretical debate on the experiences of multiple researchers across a colour difference to reach the conclusion that: 'Conducting research in a racialised field of power in the context of racial disparity and oppression has methodological consequences.'

The consequences can be both positive and negative. Positive in the sense that the participants do not assume any

researcher 'taken for granted' knowledge, and negative in the notion that 'whites are basically incapable of grasping black realities' (Wilson, 1995: 324). Merton (1972) recommended that it is optimal to have both racial insiders and outsiders conducting research, because they reveal different, not better kinds of knowledge. The cross-cultural nature of the research on birth in Pakistan and subsequent implications constitute an important strand that weaves through the findings. In Adler's (1995) demography of ethnography, only 5% of submissions to journals addressed race and ethnicity and none dealt with how racial ideologies and positions affected research method: 'After decades of self-reflexivity among ethnographers analysing the practices of writing and conducting field research, the lack of sustained attention to racialised dilemmas is particularly noteworthy, considering the degree to which other axes of power have been theorised' (Twine and Warren, 2000: 5).

Further consideration also needed to be given to the perspective represented by Tuhiwai Smith (1999: 42): 'When research is mentioned in many indigenous contexts, it stirs up silence, it conjures up bad memories, it raises a smile of knowing and distrust.'

The depth of experience (of both the women interviewed and the author's own field experience) poses a major challenge to qualitative method. For decades, qualitative researchers have been concerned about the neglect of the inner realm. Arguing that theory and methodology do not adequately take account of the deep emotions or what has been referred to as 'brute being' (Gubrium and Holstein, 1997).

In cross-cultural research of this type comparability of meaning in absolute terms is an unsolvable problem. Birbili (2000: 2) believes: 'Almost any utterance in any language carries with it a set of assumptions, feelings and values that the speaker may or may not be aware of, but the field worker, as an outsider usually is not. Even an apparently familiar term or expression for which there is no lexical equivalence might carry emotional connotations in one language that will not necessarily occur in another.'

Some linguists (Temple, 1997) suggest that the effort should be directed towards obtaining conceptual equivalence and this is greatly facilitated if the researcher and interpreter have a proficient understanding of the language also, as Birbili (2000) puts it, an 'intimate knowledge of the culture'.

In recognition of the author's cultural difference and stance as a researcher, that of 'an outsider looking in', the method was further refined as 'interpretive ethnography' (Denzin, 1997). Ashworth (1997: 21) states: 'Description cannot avoid interpretation and whilst trying to keep empathetically in tune with the life-world of the participants, there is an inevitability of the researcher making an interpretation. The interpretation cannot be de-historicised, (acontextual) or a-cultured.'

#### **Discussion of findings**

##### *The Dai, special and influential*

The women spoke of the Dai as a trusted, special and influential member of the extended family and community. Her role was clearly understood by the women, 'she was called in

labour' (Sha Pk, Shad PK, Bas UK, Farn UK). The Dai was called to perform duties that no one else was prepared to undertake (Chawla, 2000). The mother-in-law or other female member of the family had already made the diagnosis of labour based upon observation of a change in the woman's behaviour.

Birth at home in Pakistan, no matter what social class or caste involves calling the Dai. The family may have their own Dai, who may be a blood relative, have honorary family membership or simply be a member of the community (Fournety, 1997; Chawla, 2000; Kamal, 2002).

The relationships with other women present at the birth may differ if the Dai were attending as one of her own family. She may well be the 'other' special person present at the birth, which could be the mother or sister-in-law (sas). However, it was still necessary to call another Dai to undertake the defiling work of touching the genitals, undertaking vaginal examinations, cutting the cord, dealing with the placenta, cleaning up the blood. The best Dais appeared to be the woman's mother or mother-in-law.

The mother as the Dai, only delivering family members, is an accepted norm within the social fabric of the Pakistani community:

*'My mother was a Dai, but only for the family, she knows everything, you know, my mother, even though she was uneducated'* (Dil, UK).

Women felt safe and secure in the knowledge that the Dais caring for them were 'relatives'. The 'relative' care would engender confidence and mutual trust, providing a firm grounding for a normal birth. However, existing text on birth in India questions the capabilities of the Dai:

*'It is inappropriate to regard the Dai as the expert midwife in the contemporary western sense, as it is the senior relative, usually the sas (mother-in-law), who manages and directs the actions of the Dai'* (Jeffery et al, 1988: 108).

Experience of talking to Dais and women upheld the belief that the Dai was the expert in a 'midwife' practical hands-on sense. However, decision-making was the realm of the relative.

The Dai, by being 'of the family' would be much more likely to have an understanding of the holistic needs of the child-bearing woman. Shared family norms and values create a bond of knowing that does not need to be articulated, reduced or altered in meaning through the use of words that at times may not fit. Feelings are communicated much better through non-verbal behaviour and importantly received and understood through implicit common knowledge, values and beliefs. Control and responsibility shared with Allah, as a religious priority constitutes one of the major shared belief systems that bind together a relative acting as Dai and the childbearing woman. Such joint belief systems have the potential to change priorities for action in labour. If the woman, her relatives and the Dai all believe that the labour is being prolonged due to the will of Allah, none of them would consider themselves above Allah's will, so acceptance is the norm.

Comments by the women interviewed in the UK about the Dai stressed the importance of the family and community connection:

*'The Dai was my dad's auntie... she lives in our street, only a few homes away... she is looking after me'* (Farn, UK).

*'My aunt (dad's sister) is also my mother-in-law... she is the Dai'* (Naz, UK).

*'The Dai was very kind, she delivered all my brothers (I got six and one sister)'* (Fari, UK).

*'Yeh... they (Dai) looked after her (grandmother)... the family system,... most of the family used to look after her when she was in labour'* (Sam, granddaughter of Taz, UK).

*'The women in the family... because it was quite a big family they looked after her'* (Taz, UK).

*'She, the Dai is in the same village, her mother was also'* (Bas, UK).

*'My sister became a Dai, it was the only way to get some money'* (Nas, UK).

*'The Dai was/is a family thing'* (Ami, UK).

Although the women were happy to 'own' the Dai as a member of the family, there was a feeling that the women did not want her low social status to be attached to their family: *'It is not something you would like your family to do... it is in the family, but not every family allows it... the families that do are on the poor side or may have no husband... being a doctor, now that's something else'* (Taz, UK)

One of the women's daughters told the story of what the Dai and her mother-in law were doing to support her mother:

*'The family Dai looked after her... when she started in labour... no antenatal care... everything was OK... she would stay at the later stage. Most of the time she (Dai) would sit in the corner with a hookah pipe. Towards the later stages, they (Dai and mother-in-law) would squeeze and support her... tell her she was doing well and check her (pointing to the abdomen) to see if the baby was going down. The Dai used to do internals to determine goodness knows what... and press really hard on the (Ami's) back, put a lot of pressure'* (Ami, UK).

The presence of a mother who is a Dai (only for her family) brought with it a reassurance that appeared to temper the fear of childbirth:

*'She'd (mother) never 'do it' for other people, only family and grand-children... I trusted... I knew although I was frightened'* (Dil, UK).

Women interviewed in Pakistan placed the same emphasis on the Dai as a member of the family, but more in a 'what other way is there' sense. This may be due to them not knowing any other system:

*'All my babies were born at home with the Dai, children happen quickly; the Dai cut the cord and took away the placenta'* (Aia, Pakistan (Pk)).

*'A Dai delivered both children... at home... there were two other women with me, my father's sister and my husband's sister... both babies cried at birth'* (Sha, Pk).

When significant persons are the caregivers, the potential for providing holistic care increases exponentially. The parallel that immediately comes to mind is that of a mother, who is also a midwife, providing care during the birth of her grandchild. Some UK midwives, managers and supervisors frown upon a midwife 'midwifing' for relatives or close friends. They use the argument that 'being too close' can affect

rational thinking (personal experience). This nervousness has spawned a protocol for use in some hospitals. This argument appears to ignore the benefits to the childbearing woman who knows and trusts her relative to make the decisions, giving up herself to the care and supervision of the person who either gave birth to her or has known her from birth.

However, not all the women had been satisfied with the Dai. Shu's Dai was not her relative, she *'should have gone to hospital, but there was no one to take her as her husband was working away and there was 'family friction': 'The Dai complicates things' (Shu, Pk).*

#### *'Dai handled'*

Although the Dai was considered by the women interviewed to be important and influential to the family, she was valued somewhat differently by hospital staff (Dr Q, PK). In the hospital the authors visited in Islamabad, Lahore and Karachi the phrases 'Dai handled' and 'Dai practice' were synonyms for dangerous practice. Dais were accused of stretching the woman's perineum and/or cervix, pushing on the fundus and giving oxytocin indiscriminately by inappropriate route at the wrong dosage, and not referring women to the hospital (Kamal, 2000). Women came to the hospital when they had been in labour for many days, with babies dead inside them, mothers with ruptured uteri, who were febrile and at times moribund (diary record). The rural poor women generally had no resistance to infection due to chronic anaemia as a result of poor nutrition; they were overworked, physically worn out from repeated pregnancies and chronic infection (Awan, 1996). The Dai were blamed for the women's poor condition on arrival at the hospital. However, other factors influence whether transfer can be undertaken. UNICEF (1989) found that only 35% of the rural population in Pakistan lives within an hour's walk of a health facility. The woman also needs permission to travel, firstly from her mother-in-law and then maybe the elders of the village. Other influences such as cost of transport and the reputation of the hospital were more likely to delay transfer.

Similar problems were noted by a midwife in Mexico: 'Do not blame us for failing to transport women. We know when we should transport, but none of us have cars, nor do our clients. The buses run very irregularly, there is no ambulance service and if there were, our clients wouldn't be able to pay for it and the only taxi driver in our town charges more than the women can pay. How do you expect us to get our clients to the hospital in a city one hour away? No we can't, we just have to do our best' (Davis-Floyd, 2000: 4).

Paradoxically it could be argued that the clinical practice of the doctors and the midwifery staff at the hospital is as unsafe as the Dai practice, but for different reasons. Interviews with Dais confirmed that the woman and her relatives were afraid of being 'hospital handled', so are often reluctant to go to a hospital for the birth:

*'The midwives at the hospital were no good; they complicate cases to get money' (Shu, Pk).*

Commonly there is fear and distrust of hospitals and their

personnel, for example, stealing or swapping a healthy child for a sick or dead one, or swapping a boy for a girl (Chawla, 2000). Doctors and midwives generally treat the woman with disdain and the midwifery practice was far from evidence based (Chesney, 1994). Women were put in the lithotomy position for the birth, their abdomens were pushed upon and the person delivering the baby would manually dilate the vulva and pull on the baby's head before it had chance to negotiate the birth canal. In technical terms, restitution or rotation had not taken place (Chesney, 1994). During the early visits to Pakistan, all women had intravenous fluid in situ containing oxytocin to stimulate the uterus. It was custom and practice for the woman to lie flat on the bed in labour and then assume the lithotomy position for the birth. All women having their first baby were given an episiotomy.

The practice seen in this hospital may not be reflective of that undertaken in other hospitals or in the home. In fact the Dai is unlikely to embrace this practice at home, as she encourages the woman to walk about in the first stage of labour and adopt the squatting position for the birth, the position alone may mitigate against pushing on the fundus and manually dilating the vulva.

Because the author had not been familiar with the practice of pushing and pulling by hand, she immediately judged this practice as being 'unsafe'. This stance is documented by Jordan (1993) as being typical of superiority and she coined the phrase 'moral requiredness' (thinking one's own practice is the right one).

On reflection, a parallel practice of pushing and pulling with drugs and instruments, not hands became evident within practice in the UK. As a midwife trained in the late 1970s, the author had accepted without question the practice of a 30% induction rate (pushing with drugs) and the current instrumental and operative delivery rate of between 20% to 25% (pulling with instruments) as part of everyday practice. It became evident that the author had been socialised in the belief that 'educated' doctors and midwives could make the decision to push and pull with drugs and instruments and the practice was considered safe, thus given an authoritative status. Yet the easier to control and less invasive practice of pushing and pulling with hands was abhorrent. A difference also lay with who was undertaking the pushing and pulling. In the hospital in the UK, it was the employed midwife and doctor with loyalty and accountability to the organisation. In the home in Pakistan, it was the Dai and female relatives, who were all known to the childbearing woman, who had strong loyalty and accountability to the family.

Reviewing the rationale that underpins the reputation of the Dai, whether this is as birthing woman her relative or hospital staff, sheds light on the birth experiences of women in Pakistan.

#### **Conclusion: 'dai handled, hospital handled'**

It has been important to explore in some depth the methodology of the research due to its cross-cultural nature. The literature review depicts women as being unhealthy due to poor

diet and no available health facility. The main theme that has been focused upon reveals divergent perspectives upon the Dai who attend over 80% of birth in Pakistan. The women interviewed told of her essential presence at birth and the importance and optimum position within the family. Her role was in assessing progress, providing support and dealing with defilement. Alongside the unpopularity of hospital birth for some women, hospital personnel and policy-makers are

highly critical of Dai practice.

Prior to this research study, there was little evidence that captured the positive aspects of Dai practice, perhaps this was because no one asked the women receiving their care.

Further research is needed into whether the women call the Dai because there is no one else available, and whether Dai practice is indeed essential to the wellbeing of the mother and baby or dangerously harming them.

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