Role of Traditional Birth Attendants in Family Planning

Proceedings of an international seminar held in Bangkok and Kuala Lumpur, 19-26 July 1974
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Traditional Birth Attendants
in Family Planning
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Reginald MacIntyre

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TRADITIONAL Birth Attendants (dukun bayi) are one of the many kinds of traditional healers found in Indonesia, a country of more than 120 million people with many tribes each with their own language, habits, beliefs, and culture. For example, there is the dukun pijat, a specialist in massage. It is still a belief in many tribes that illness can be caused by a malfunction of the organs of the body (e.g. muscles, blood vessels, and nerves), and especially when the nerves and the muscles are involved, massage is performed. There is the dukun who specializes in healing fractures and bones, and the dukun who can be called for assistance or advice in deciding the best day or date for undertaking a big job (e.g. building a house, to throw the paddy seed, or to find the luckiest date for a wedding party or other festival). And finally there is the dukun bayi, the traditional birth attendant (TBA), who is perhaps the only one used in the rural areas, and in the cities by the low-class people.

The Role of the TBA

The TBAs are usually middle-age women (on the island of Bali we have male dukuns), illiterate, and with skills inherited from their family (grandmother, mother, or aunts). These old women are highly regarded in the community, and assist the people without concern for monetary reward. They are usually peasants and their profession as a birth attendant is not their main job. They will provide assistance for long periods, from early in the pregnancy until 1 or 2 months after delivery, if necessary.

Another reason the TBAs are taken in as a member of the family and get the ultimate confidence and privilege to be called grandmother, is because she will be the central figure in preparing the offerings for the several ceremonies or rituals during the course of the pregnancy and after. She will also be the person who takes care of the placenta, finds a suitable name for the baby, prepares the indigenous herbs, and does the massage. She provides a feeling of safety and protection from evil for the whole family. Some TBAs are also able to do the external manipulation to retroflex the uterus for spacing purposes.

Before the birth a good relation and understanding usually exists between the family and the TBA. During the several prenatal visits she will give advice about manners and good healthy living during pregnancy (e.g. she will mention about the taboos and forbidden foods, she warns the family that a pregnant mother should behave well, is
not allowed mocking or laughing at handicapped children, killing animals, etc.).

There is not much for the TBA to do while the mother is delivering except to pray for a successful birth. During difficult births, the TBA will massage the mother. Those TBAs who have undergone training in the MCH clinics, in preparing for the arrival of the baby, will boil water, sterilize instruments, prepare the "delivery bed," and in case of difficulties she knows that she should call the trained midwife immediately.

After the baby arrives, the TBA will cut the umbilical cord with a pair of scissors, a knife, or a piece of sharp bamboo. She then uses some indigenous herbs in the form of a paste (sometimes ashes or alcohol) to be put on the wound, and then bathes the baby and dresses it in warm clothes.

The TBA will bathe the mother, dress her, and apply a binder around the abdomen. She will then get the drinks (indigenous herbs) to accelerate the exit of "unclean blood" from the uterus and the excretion of mother's milk. The TBA will visit the mother daily for 1 or 2 months after the birth. During this period several taboos are prescribed again, although they are different from those in the prenatal period.

With a small ceremony the placenta is buried at a place located by the TBA. It is usually put in an earthen bowl and carried by the father escorted by the TBA and the family.

**Future Role of TBAs**

The TBAs in Indonesia still have considerable influence in the daily life of the people. They are respected people and are capable of communicating well with women and of understanding the problems affecting their lives. In prenatal care, during child birth, and in postnatal care particularly for those who are living in the rural areas, the TBA is still needed, since 80–90% of the deliveries are still conducted by them. With regard to family planning, they are still bound by the traditional beliefs. Due to their ignorance about the physiology and anatomy of the human body, and also not being aware of the state of health of the mother, mortality is high both for the mothers and the babies.

The Ministry of Health is aware of the situation and would like to end this malpractice. However, for the time being it is not possible to prevent TBAs from attending births. Lack of qualified midwives to replace them is one reason why the government cannot yet take steps to lessen the hazards. A household survey in East Java shows that the more remote the village, the more is requested of the TBAs.

In urban areas only 2.5% seek help from TBAs, while in rural areas with fairly good communication the figure is 6–10%, and in areas with bad communication, 37%.

Data (1973–74) from the Ministry of Health show there are 6211 doctors, 8323 midwives (of which 4767 are working in MCH), and 1834 assistant midwives working for the government (Ministry of Health). There are approximately 60,000 TBAs in Indonesia. This means a ratio of health worker to population for doctors 1:20,000, midwives 1:25,000, and TBAs 1:2000. So cooperation with TBAs should be sought and since the early 1950s efforts have been made to register the TBAs and recruit them for courses in MCH clinics. Only half of them responded.

The trained TBA is not only taught how to do the delivery in a hygienic and less hazardous manner, but is also asked to report births and deaths of infants and mothers. Vital statistic data collecting is not yet a routine activity in Indonesia.

When the national family planning program started 4 years ago, the possibility of using the TBAs as FP motivators was discussed. However, more information was needed about the characteristics, the social status, and influence of the TBAs in the community, as well as their knowledge about, and attitude toward, family planning.
If we want to use the TBAS as agents of change in attitudes in the community, we need more studies and surveys.

Does Sampoerno and Talogo found that in two districts in Jakarta the age of the TBAs ranged from 40 to 70 years, and only 13% were below 40. Eighty-two percent had no schooling, and 16% finished elementary school or reported having attended junior high school.

Another study in Central Java (Temanggung and Secang) revealed that almost 90% of the TBAs were Moslems, 7.5% Buddhists, and 2.5% Catholics. Sixty-five percent of the TBAs interviewed reported that they were engaged in other types of work in addition to practicing midwifery. When asked about their attitude toward family planning, 26% of the 205 were willing to support the movement, 43% had no objection to family planning after it was explained to them, and less than 9% were opposed.

Different types of training and curricula in family planning were surveyed in Central Java (Temanggung and Secang). A number of TBAS were recruited, given simple training in family planning, and their effectiveness as agents of change and acceptor seekers was evaluated. The performance figures for referrals was disappointing. Apparently they obtain an average of only two or three acceptors per month. The number of acceptors starts relatively high, but then declines. In spite of this, however, the government is still convinced that TBAS can be used effectively in the family planning program.

**Implementation of the Program**

The government took the following steps to initiate the program: more guidance was given to the government midwives on how to train the TBAS; the course was improved, and further research and surveys into the role actually played by the TBAS were carried out. The training programs are now designed to increase awareness of the importance of family planning; obtain the cooperation and participation of the TBAS; give clear and precise instruction, and to practice techniques taught.

The achievements of the TBAS as FP motivators will depend on the guidance given by the government midwives, the services conducted in the clinics, and the presence of a female doctor in the clinic.

The midwife should be able to speak the native language of the TBA and should not use difficult medical terms.

The services at the clinic should put the mothers at ease, and care should be taken by clinic staff to avoid long waits for attention or service.

The presence of a female doctor will encourage the mothers to come for FP services especially when the method chosen is the IUD.

A workshop held in Jakarta in August 1972 on the role of the traditional midwife in the family planning program came out with some important recommendations, including: registration of all TBAS through formal and informal leaders; formal relationships with the TBAS should be through the village head or formal leader (technical operations should be under the guidance of the MCH centre or midwife); good relations must exist between TBAS, health officers, and other family planning personnel; training is essential, and should follow a uniform curriculum and be carried out with due consideration of the local situation; training should be directed toward making the TBAS aware that family planning is important for the welfare of the mother and children; detailed operational planning is necessary for the participation of TBAS in the FP program, particularly in regard to their relationship with the community leader; and utilization of TBAS should preferably be restricted to reporting, dissemination of information, escorting their acceptors to the clinics, and distribution of condoms.

Many of these recommendations have now been adopted and used as guidelines in developing the program. During 1972–73,
14,380 TBAS were given additional training in family planning as follows:

<table>
<thead>
<tr>
<th>Province</th>
<th>TBAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DKI Jakarta Province</td>
<td>100</td>
</tr>
<tr>
<td>West Java Province</td>
<td>2,625</td>
</tr>
<tr>
<td>Central Java Province</td>
<td>6,750</td>
</tr>
<tr>
<td>DI Yogyakarta Province</td>
<td>405</td>
</tr>
<tr>
<td>East Java Province</td>
<td>4,500</td>
</tr>
<tr>
<td>Bali Province</td>
<td>−</td>
</tr>
</tbody>
</table>

Until 1973, the family planning program was limited to the six provinces on Java and Bali, the two most populated islands, containing two-thirds of the population of Indonesia.

The performance figures for referrals are disappointing, as stated earlier, with only two or three acceptors referred per month and these mostly not postpartum. The TBAS, after training, start with a high number of referrals but then the number declines. Most referrals are made by only a small portion of the total force of TBAS. There is considerable variability in the performance of TBAS. What are the reasons for the poor performance? Initial success was possibly due to the existence of a comparatively small, already-motivated group within the community. The remaining groups within the community possibly include those who are either indifferent or opposed to the family planning program; or it may be merely a question of distance if the community is located far from any service and information facilities. It is expected that through the development of better facilities the activities of the TBAS will increase in the future. Mobile teams might be one way to solve the problem.

It is important to realize that because of her position within the community, particularly in rural areas, TBAS may become obstacles to the program. Therefore, it is strongly recommended that efforts be made to secure at least the passive endorsement of the program by the TBAS, even if their active cooperation cannot be obtained.

The Future

Assuming that a TBAS is only capable of acquiring two or three acceptors monthly, we should not expect them to make a significant contribution toward the family planning program. Nevertheless, their contribution to the program is very much appreciated.

Experiments should be carried out to find more effective methods of using TBAS in the FP programs. A simple curriculum for illiterate personnel should be prepared, and methods developed for making training and participation in the FP program attractive (e.g. incentives, course certificates, badges, etc.). Refresher courses, guidance sessions, and evaluation should be conducted in the clinics on a continuing basis.

The management and implementation of the TBAS project should be handled by an agency set up for the purpose, and evaluation should be conducted on an on-going basis.