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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Editors: J. Y. PENG, SRISOMANG KEOVICHIT, AND
REGINALD MACINTYRE

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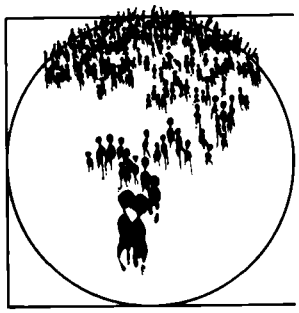

Outlook and Future Research in the Malaysian TBA Program

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MY discussion on this topic will be derived mainly from the experience gained from the Malaysia program on utilization of kampong bidans (traditional birth attendants) in family planning which has been carried out for the last two and a half years.

In 1970, the National Family Planning Board and the Ministry of Health of Malaysia started the training of TBAS. The 3-week course consisted of 1 week for maternal health, 1 week for family planning, and 1 week practice with the local health authorities. UNICEF supported this training program and a midwifery kit was given to each TBA after the training. Although the intention was to utilize this group of people at that time nothing happened until 1972. In 1970, the AID started to support family planning-related programs in developing countries through the well-established population units in three major universities in the USA. Since I have been with the University of Michigan, it is one of the three universities we proposed to AID for this Universities Services Agreement Grant, to have a project of utilizing TBAS in family planning services in Malaysia for a 3-year period. The project was funded and the field program started in early 1972. An operational unit was set up in the NFPB for this project. The project implementation and operation has been, at the same time, a gradual learning process for us which will help toward the development of a well-designed program.

Before implementing this project we asked ourselves the following questions and tried to work out the best way to operate: (1) What functions should we ask the TBAS to perform? (2) What system should be designed for the operation? (3) How should we recruit and train them? (4) What would be the optimum performance target? (5) How should we compensate the TBAS? (6) What supervisory channel should be created? (7) How should we assess individual performance for suitable action to be taken? (8) How should we evaluate the success of the project?

The implementation of the project was made first in the state of Perlis and Malacca in January 1972 and gradually expanded to other states. By May 1974 nine of eleven states in Peninsular Malaysia had the project with a total of 188 specially trained for this purpose, and 151 TBAS still active in the program.

A total of more than 4000 new acceptors were recruited by the TBAs, with an average of two new acceptors recruited monthly by each TBA. The highest number of acceptors recruited was 20 a month by a TBA in Kedah. As of May 1974, 68% of these new acceptors still continued to receive resupplies. These acceptors were almost all on oral contraceptives.

In discussing the outlook and future research for this program, I would like to follow the eight questions previously raised in organizing the Malaysia TBA program.

Functions

We requested TBAs to perform two main functions: i) To recruit new acceptors and to encourage program dropouts to return for family planning, and ii) To resupply oral pills once the initial acceptance is made at the clinic.

We also asked TBAs to support MCH services by bringing prenatal mothers, attending deliveries with qualified government midwives, and then bringing postpartum mothers to the clinic for family planning. The question here is: should we limit their function to only family planning or should they be asked to include MCH services? I am sure all of us will answer "yes." If we include MCH services in the TBAs' work, then what would be the best way she could contribute? We should also be interested in the way they motivate mothers, how they talk to mothers and how they convince mothers in different situations and with different personalities. In our experience in Malaysia as of April 1974, they recruited between 11 and 31% of their own postpartum mothers for family planning, with different proportions between the various states.

System of Operation

We designed two types of coupons in the simplest and most concise way to ease operations and for efficient data collection. There were yellow coupons for recruiting acceptors and green coupons for resupplying oral pills. We found the coupon system a good way to operate. The initial supply of pills was made by nurses at the clinic based on the yellow coupons and resupplying was made by the TBAs based on the green coupons.

We designed fundamental operational steps. This operational system includes: i) Recruitment of family planning acceptors by TBAs; ii) The initial acceptance coupon (yellow coupon) and accompanying instructions; iii) Visit of TBA acceptor to health centre to receive family planning; iv) Resupply by TBA using green coupons; v) Failure to come for resupply; vi) Monthly meeting between TBAs and nurses at the NFPB clinic/health centre.

We found these steps very satisfactory not only for operational purposes but also for training. Experiences in other countries may have a better way of operating their project so we should seek methods to develop the best system for all countries to follow.

Recruitment and Training

Although it is estimated that there are about 3000 TBAs in Malaysia, the number officially registered, according to the Ministry of Health, is 1888. Of this number a total of 992 were trained for 3 weeks. The recruitment of TBAs for this project was made out of these 992 trained individuals. The recruitment was made through the local health authorities based on the judgment and knowledge of the nursing supervisors in each state. We try to limit the age up to 65 but often find some over 65 in very active condition and we had to take them. The number of deliveries by TBAs is also one important factor for recruitment. Some other factors such as transportation (car, motorcycles, and bicycles), an area where some TBAs live close to each other, etc., would be important for selection of TBAs.

With regard to training, content, duration of training, method of training, and conduct of the course itself will be important factors to consider. The training we conducted was very specific with emphasis on learning by doing and by role-playing as frequently and repeatedly as possible. Since they already

had 3 weeks of training (although they had forgotten most of the training part), our training was short (3 days) being a simple and concise lecture followed by confirmation of their knowledge through frequent questioning. Nobody escaped the questioning. The training concentrated on the practical exercise on the six steps mentioned previously. Actual coupons and oral pills were used for the training. During the course, TBAs were assigned to supervisors and to a clinic. TBA–supervisor relationship, proper channel of instruction, and communication and personal relationships were established during the 3-day training period. They stayed together in a hostel and a practical session during the evening time was organized. They were given coupons and oral pills, they remembered their supervisors, their clinic, and their code number. They were also given a book to record their deliveries with identity card numbers of mothers for future research. Although most of them cannot write they managed to ask a family member to write on their delivery book.

Performance Target

For the new acceptors we hoped that each TBA would recruit five new acceptors a month. This target was not reached, although some recruited more than 10 a month and some none, which resulted in an average number of two new acceptors a month. The more important part is the resupply of pills for those mothers who already accepted the initial supply from the clinic nurses. As the project progresses the number of mothers for resupply increases (e.g. a TBA in Malacca reached a high of 110 mothers for resupply). The problem here is the workload of one TBA to have so many mothers for resupply. One of the TBAs persuaded the mothers to have tubal ligation or the husbands to have a vasectomy to reduce the number of resupply. She also tried to give three to six cycles of pill resupply at one visit. The question of what would be an optimum number of active users one TBA can have should be carefully studied.

Compensation

What would be the most reasonable way to compensate the TBAs for their work? Should compensation be in the form of incentive payment, salary, allowance, piecework payment, or a combination of these? Because of the possible risks of piece-work-type payment, we started to pay a flat allowance to each TBA each month. A bonus-type incentive payment was made periodically according to performance in terms of the number of new acceptors recruited, number of resupplies of contraceptives to mothers, and the assessment from their supervisory nursing personnel. The monthly allowance was also increased to TBAs with excellent performance. Other than this material reward, the moral support from headquarters people as well as supervisory personnel has been emphasized. We try to work with TBAs and supervisors as a family team.

Supervisory Channel

The most important supervisory channel was a monthly meeting designed for working purposes, and for receiving allowances by the TBAs from their supervisors at the clinic. The steps for the monthly meetings are clearly designed and effectively carried out. We suggested that supervisors visit the TBA's home once a month but this was not done. It seems there was no need because some TBAs came to the clinic more than once a month to see nurses and to get more supplies. Through this working relationship and personal contact a mutual understanding between a TBA and a supervisor is firmly established. We consider this supervisory factor to be one of the most important for the success of the program.

Assessment of Performance

The routine assessment of performance is made through the coupon sent in to the clinic and then to the headquarters. The number of acceptors recruited and the number of resupplies performed are recorded by the individual TBA. If a TBA shows no performance, she gets a warning. If she continues to perform unsatisfactorily, she is dropped from

the project. On the contrary, if a TBA does a good job her record will be good for a bonus and increased allowance. We keep a schedule of follow-up meetings with TBAs in the local areas. At this follow-up meeting the amount of bonus by each TBA is decided. the amount of increase of allowance is also suggested, and the bonus is given right at the meeting. If they performed well they are asked to inform their colleagues how they did so well. Those who did not perform well are asked to describe their difficulties and problems. From our experiences, we found that those who received a bonus and increased allowance continued to perform well. This type of incentive apparently worked well. We think this follow-up meeting is very important and recommend it to other programs.

Evaluation of the Project

How do you measure success in this type of project? Do we measure it in terms of the number of acceptors recruited, continuation rate, degree of participation in MCH services, number of motivations made by the TBAs, or all of these factors. These people are not employed, but are asked to work on a part-time basis. If the allowance is not sufficiently high, the cost effectiveness for the program will not be high. We plan to carry out a survey to interview acceptors, TBAs, and supervisors for the assessment of the value and practicability of this type of program.

So far I have concentrated my discussion on the organizational and operational aspects of the program of utilizing the TBA. I would now like to summarize the future outlook for the program in four general areas:

1 Even with limitations in utilizing TBAs and the existence of qualified auxiliary health personnel in a rural health scheme, is it worthwhile continuing to use the TBAs? If the answer is yes judging from their performance, efficiency, and cost effectiveness, in what field should they be used: exclusively for the family planning program or for both MCH and FP?

2 What is the best way to organize this group of people to carry out an effective program?

3 Can we unite and identify more countries with this type of personnel, and recommend a standardized organization and operation? In other words can we have regional planning and cooperation?

4 How long can this group exist and be utilized considering the future development of health manpower and health facilities of a country? What would be the policy of the government in determining the future of this type of personnel?

In Malaysia, we tried to work out a cost figure for each acceptor recruited from the operation in the four states in 1972. This figure was obtained only for the direct project operational costs, not including costs such as health facilities, existing health personnel, or contraceptives provided by the government. It cost $4.67 to recruit one acceptor only counting the payment to the TBA, $5.63 including training expenses, $5.87 to include follow-up meetings and bonuses. If it includes headquarters staff travel for training and supervision, and petty cash operational expenses in the local areas, the cost becomes $9.00 for each acceptor recruited. The encouraging part is that continuation of the resupply of contraceptives is high. It seems that there is more personal attention to the users by these TBAs.

At the present time in Malaysia there are about 2000 qualified midwives, and more are urgently needed. Thirteen training schools of midwives in Malaysia are producing about 140 graduates per year. It would seem that TBAs will continue to be active at least for the next 20–30 years. The number of registered TBAs at the Ministry of Health is 1888 and about 40% of deliveries in Malaysia are being attended by this group. It may take even longer than 20–30 years to take over the functions of TBAs by qualified midwives. Since they will continue to be active in the foreseeable future, I believe that we should

utilize them in the best organized way for both MCH and FP. I would also like to propose establishment of a channel for regional cooperation among countries in Southeast Asia for this type of program. How we organize, how we can carry out the program in a somewhat standardized way, and how we can develop regional cooperation for this program should be resolved. If we are going to utilize this group of people at all we must have a well-organized system of operation and supervision. From my experiences in Malaysia I am convinced that most of the TBAS are good people and try to do a good job. How to make them function efficiently rests with us.

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