Role of
Traditional Birth Attendants
in Family Planning
Proceedings of an international seminar held in
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Editors: J. Y. Peng, Srisomang Keovichit, and
Reginald MacIntyre

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The Government of Malaysia initiated a National Family Planning Program in 1967. The plan is to initiate a family planning service program in the urban/metropolitan areas first, and then expand the program to the rural areas, through functional integration with the Health Services of the Ministry of Health. Such integration will effectively and economically expand services. The Board intends to utilize all available channels, organizations, and individuals to propagate the concepts of planned parenthood. Hence the plan to utilize the Traditional Birth Attendants to provide FP services.

The TBAs are still very active and influential in the rural communities. There are at least 3000 TBAs still active in Peninsular Malaysia and 40% of the total deliveries are still being conducted by them. The number of deliveries conducted by the TBAs differs from locality to locality depending on such factors as the availability of health facilities within the community and the historical relationship that has existed between the community and the local TBA.

Realizing the importance and the influential nature of the TBAs, the National Family Planning Board and the Ministry of Health launched an orientation course in 1970 to sway the TBAs toward the concepts and practice of modern midwifery, public health, and family planning. By mid 1974, 1000 TBAs had received this orientation course. It was also hoped that the orientation program would result in spontaneous participation by TBAs who had undergone previous training and orientation. However, it was noted that many of the TBAs did very little with their training and this led to the development of action-oriented plans to utilize TBAs to provide services especially in those areas which are inaccessible to either the Board or health staff.

In developing the action-oriented program, many steps were taken by the Board. They include: the formation of a body called the “Operational Unit” consisting of members of the Board’s senior staff and Ministry of Health officials; specifying the main and specific objectives to determine the short- and long-term implications of the project within the context of the National Family Planning Program; developing a manual/guideline for the trainers; scheduling training programs, developing a system which could be easily
understood and followed by the TBAs; payments; and supervision. The most important task of the Operational Unit is to evaluate the success of the project.

The main objective of the project is to determine the extent to which TBAs can be utilized to provide services without jeopardizing their source of income. The specific objectives are as follows: (a) to study the receptivity of the TBAs to improved methods of midwifery; (b) to study their receptivity and acceptance of modern concepts and practices of planned parenthood; (c) to determine the role they can play to enhance the achievements of the FP program; (d) to strengthen the relationship between those who are involved in the family planning program and the TBAs; (e) to determine the suitability of the TBAs to carry out certain functions and responsibilities assigned to them; (f) to assess the administrative, educational and technical implications such as logistics, supplies, and supervision of the project; and (g) to assess the financial implications (cost analysis) of the project in comparison with the national program.

Attitude of TBAs

At present, the TBAs play an important role in extending certain services to the community. Discussion with the various categories of health staff revealed that many of the TBAs who had been previously oriented about the concepts of modern midwifery had not utilized their knowledge. They continued to use methods that had been handed down by their grandmothers. This may be due to the very concepts of health in the rural community as the TBAs are still not convinced about the advantages of the modern techniques. Determining their attitudes toward improved methods will undoubtedly help to define the role they can play in the future health services in rural areas.

Since the TBAs are very influential in the rural community, ideas propagated by them will to a certain extent influence the rural community toward acceptance of planned parenthood, and in particular toward the modern methods of contraception.

At present, the TBAs play a major role in extending some of the functions of the health staff. Many health staff feel the TBAs cannot be utilized for family planning activities, because this means preventing births and thereby cutting off their source of income. But so far no substantial evidence has been produced to support this view. In order to define their role, it is important to assess objectively the role they can play in the community and work out a systematic schedule so that their work contributes toward the goals of the Family Planning Program.

The relationship that exists between the TBAs and the staff at the Rural Health Units must be studied and analyzed to determine how best the TBAs can be utilized in the program. All areas must be identified to strengthen the relationship so that the services to the community are properly coordinated.

TBAs can play various roles in family planning, including dissemination of information on family planning, motivation, referrals, and defaulter tracing. It is vitally important that at least certain roles identified as the “most important” should be spelt out in clear terms so that training can be directed toward the functions expected to be performed by the TBAs.

The administrative implications include the resources available, compensation payments, additional resources needed to begin and sustain the project, the financial arrangements, and the implications of the system on the total program, such as supervising, etc. Many studies have shown that an excellent quality of care can be provided by a minimum number of trained workers under good supervision in an organized setting. It has been emphasized that the success of this project will probably depend more upon the competency and attitude of personnel than upon any other factor. The competency and supervision of personnel will depend largely
on the quality of guidance. Supervision is particularly important not because of the numbers but because of the need for continuity.

The utilization of the TBAs can provide a rationale for the study of a specific family planning program through the use of commissioned door-to-door field workers to promote contraceptive knowledge in the country. The employment of these people could: i) strive at a critical balance of generating more effective demands to utilize fully the available clinic facilities; ii) reach a scattered, illiterate population; iii) complement the program by initiating workers from the same socioeconomic strata, operating under the strict control of an existing organization; iv) generate and continue to generate a certain amount of controversy in terms of effectiveness and social costs; v) examine the widespread criticism of the use of monetary incentives for individual promoters such as the TBAs who in their enthusiasm for recruiting acceptors, will not educate the community, or may even misrepresent the nature of the program; or those who will motivate solely for pecuniary incentive rather than a concern for family planning thereby realizing an exorbitant income; a precipitous drop once this scheme is withdrawn and fear of malpractice and doubts about the propriety and the long-term consequences of the program.

With the above objectives and various views on the pros and cons of the program, an action-oriented project was initiated in January 1972 under the sponsorship of the National Family Planning Board, Ministry of Health, and the University of Michigan, and is financially supported by the Office of Population of the USAID through the University of Michigan.

Since the National Family Planning Program in Malaysia is almost a pill program, the functions planned for the TBAs are as recruiters of new acceptors and as resupply agents. A coupon system is used — yellow for recruiting new acceptors, and green for resupplying.

A short-term course was designed for the project. This included a half-day orientation of the trainers, followed by two and one half days of training of TBAS. The basic operational steps were clearly defined so the TBAs clearly understood the system. These steps are: the TBA would give a yellow coupon to all eligible mothers who accept family planning; the acceptors go to the NFPB clinic/health clinic with the yellow coupon, where after routine examination, she receives a one-month cycle of pills and six green resupply coupons; the acceptors exchange green coupons for pills from her local TBA; when the green coupons are finished, the acceptor returns to the original clinic to get her regular check-up and further supply of green coupons; if the acceptors do not return for resupply, the TBAs will contact them in their homes; monthly meetings are held in specific clinics for payment, supplies, and reporting of rumours, etc., to their supervisors.

Payments

Payment consists of $30/-(Malaysian Ringgit) a month, plus a special bonus payment after assessing their performance. This assessment is done by the Operational Unit, which meets every month.

The project was first implemented in two states in 1972 and by the end of March 1974 all states except two had implemented the project. A total of 181 TBAs have been enrolled in the project. About 150 TBAs were still active in May 1974.

By the end of 1973, 4235 acceptors had been recruited by the TBAs. The average number of acceptors recruited in the first 6 months is higher than the second 6-month period. About 2% of the women who came to the clinics with the yellow coupons are not included in the acceptor figure, because they were either pregnant at the time of acceptance or, to the best of our knowledge never started on the method prescribed.

The rate of contraceptive resupply by the TBAs has been very encouraging. The aver-
age rate of resupply was 72, 68, and 56% after 12, 18, and 24 months respectively.

Present and Future Fundings

As indicated earlier, the University of Michigan, through a program grant by USAID is financially supporting the Board in implementing this program. This is expected to end in 1974. The National Family Planning Board, realizing the importance of continued assistance has requested a sum of US$120,000 for the program for 1974, 1975, and 1976. At the same time a proposal was put to the Treasury and a sum of M$20,000 has been allocated for this program.

Conclusion

The expression of fertility in developing countries like Malaysia is the function of local cultural conditions and institutional patterns. In such a context, an effective motivation and communication process is significantly relevant. In exploring the possible channels of communication, our attention has been drawn to the important role that local TBAs can play by communicating through established cultural channels. To the extent that rural fertility in Malaysia is being sustained by unique local cultural and historical tradition, action programs aimed at deliberate fertility control must also be firmly controlled by a scientifically appraised role of local TBAS using local, cultural understanding and resources.

With the above-mentioned rationale in mind, the present project was established for detailed study. Traditionally the TBAS have occupied an important position in kampong communities as maternity specialists and continue to give home services at childbirth. Their role if precisely appraised, could help to assess their usefulness in promoting family planning practices in the communities.

The recent study was designed with two sets of broad research objectives: 1) how much do the TBAS know about family planning; and 2) what are their attitudes after having been exposed to a series of lectures and demonstrations given by experts on the need for, and the theory and techniques of, family planning and modern midwifery?

Though appearing very ambitious, we took many precautions during the implementation of the program. There is no doubt that involvement of TBAS will enhance acceptor and continuation rates, but there is also an equal chance of malpractice, criticism, misrepresentation, or other complexities inherent in family planning programs.