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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Problems and Findings from the TBA Program in Malaysia

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Family planning as an isolated service does not have the public appeal it enjoys when associated with other services. This is especially true when such services are expanded to rural areas where people are illiterate and bound by traditions and cultural norms. People accept new ideas more easily if it means some relief from pressing problems. Selections of services, agencies and individuals for family planning must therefore be from those which can provide contacts with sufficiently large numbers of persons eligible for services.

In Malaysia, maternal and child health (MCH) services are obviously the most important for family planning services. Such services are not only provided by the health staff, but also by traditional birth attendants (TBAs) who contribute to the welfare of mother and child in the rural areas. At least 40% of the total deliveries in Malaysia are conducted by the TBAs. In addition to attendance at childbirth, the TBAs also look after the postnatal care of the mothers according to certain cultural and religious beliefs.

The National Family Planning Board, in consultation with the Operational Committee, formulated certain policies and guidelines for the implementation of the TBA project at various levels.

Selecting TBAs

The Operational Unit set up certain criteria for the selection of TBAs. Apart from age and other considerations, the most important criterion was that they have previous training/orientation by the National Family Planning Board and the Ministry of Health on the broad concepts of health, and related health activities that are available in the rural areas.

Selecting Areas

The Operational Unit stressed that the area of activity by the TBAs should satisfy certain criteria: a) sufficient number of TBAs trained or orientated by the National Family Planning Board and the Ministry of Health; b) availability of clinical services; c) relatively short distance between the physical facilities (NFPB clinics, health clinics offering family planning services, and the base of the TBAs); d) a good relationship between the TBAs and health staff; e) the TBAs must be popular within the community; f) a reasonable number of people in the area; and g) population of the area. The head of the NFPB
clinic must be able to adequately supervise and hold monthly meetings with the TBAs.

**Training**

The learning abilities of the TBAs varied widely. Those from well-developed areas seemed to grasp facts much better than those from poorer areas. The trainers made special efforts to train them, particularly in their homes at night. Flexible training techniques are essential.

Many of the TBAs from remote areas often become ill, making the training considerably more difficult.

Training the TBAs to issue yellow coupons to eligible couples was much easier than training them to retrieve the green or resupply coupons.

**Services**

We stressed that each TBA should enroll only acceptors who had not previously used family planning services, and not pregnant. Over 80% followed these directions, but some recruited women already practicing contraception. This duplication caused problems in the clinics.

The TBAs recruit large numbers of acceptors initially but the number drops off after some time. We assume they recruit most of the locally available women then must move out of the area to seek recruits. Their workload probably also increases allowing less time to actively seek acceptors.

TBAs not selected by the operational unit often spread false rumours about the participating TBAs.

We have attempted to drop poor-performing TBAs from the program but this has not always been possible. Some of them refuse to accept that their performance was poor. Of course it is not sufficient to merely look at the number of acceptors when judging performance. We must also be careful when dropping TBAs from the program lest they spread damaging rumours about the program.

The system of bonus payment for the best-performing TBAs has created certain problems. The present criteria, number of acceptors and continuation rate, may not be sufficient to make a selection. We should probably compare their performance with TBAs in other states.

We now feel that more time should be allocated for refresher courses for the TBAs. TBAs should be encouraged to emphasize to postnatal mothers the importance of family planning to their health.

We also need an adequate system of reporting rumours prevailing in the community during the monthly meetings.

The TBAs should be encouraged to participate in all information/educational activities conducted by the Board.

They should also be encouraged to spend more time with their new clients, to enhance the continuation rate of the acceptors.

**Conclusions**

Even with the limitations of the TBAs as outlined, I believe they can play an important role in a national family planning program. Although most TBAs are illiterate, they do communicate well within their communities, probably more convincingly than uniformed staff, because of their influential and respected position in the community.

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**The Malacca Experience**

**KUA ENG LAN**

*Staff Nurse in Charge*

*National Family Planning Board, Malacca*

Before utilizing the TBAs in the family planning program in Malacca, they are given a 3-day orientation course which is preceded by a 3-week health, obstetric, and family planning course.

The project started in February 1972.
There are 17 TBAs from three areas. All have received 1 year of midwifery training in the local hospital. Most of them have a few years of schooling, so all except two are able to read and write simple words. They are between 43 and 59 years old and are greatly respected by the villagers. They are very influential and their advice is readily accepted.

Problems

We found that some acceptors recruited by the TBAs were pregnant before or after one cycle of pills. These women were considered provisional acceptors and pregnancy tests were given as necessary.

We discovered that some TBAs were “stealing” our patients by asking them to stop the pill for a few months so that they would become eligible for recruitment as a new acceptor. We emphasized to the TBAs that their responsibilities were to bring in new acceptors and previous acceptors who had stopped practicing family planning on their own for at least 6 months.

Some TBAs complained that some of their patients went to the FP clinic by mistake, and the staff kept them as patients. The women complained that they had to pay for their supplies. To avoid such confusion, the TBAs now accompany their patients to the nearest clinic for the initial visit.

After taking pills for 1-2 months, some patients stopped because they heard that they would get cancer or if they give birth again, that the baby's body would be covered with undissolved pills, and also that their stomach would become thinner and thinner and eventually burst. The TBAs were asked to visit these women again to explain to them that the rumours were false, and where necessary the staff nurse in charge would visit the women to reassure them.

Some women worry about the “scanty” period. They think it is a sign of bad health. We explain to them that pills suppress ovulation but that this does not interfere with health.

When we started the project, only two brands of pills were used. Because of the side-effects that some patients complained about they either stopped taking the pill or resorted to herbs or witch doctors. We now have more brands of pills, condom, IUD, vasectomy, and tubal ligation. Patients are encouraged to attend the clinic during doctor's day for necessary treatment. Most of our patients are on pills, since there is a real reluctance toward IUDs or sterilization in Malaysia.

Many women have the mistaken belief that they will not get pregnant while breast-feeding so they continue to breast feed their babies for a long period. This is a great strain on the mother and baby's health will also suffer. This is an area we must pursue to enlighten the women.

During Fasting Month for the Muslims, many patients stop taking pills because they are usually too tired to have intercourse. They resume sex immediately after Bulan Puasa and many become pregnant because they did not take pills at the right time. They are advised to continue pills even though they do not have intercourse, or at least to use another form of contraception.

Some women stop taking the pill when either she or the husband is sick and they temporarily stop having intercourse.

In certain villages most of the men go to sea or seek jobs elsewhere, so the women take pills (or use condom) only when their husbands come home. They are advised that they have to take pills at the right time to prevent pregnancy.

Some of the midwives never attend the monthly meetings and this hinders our work.

There are a few TBAs who are not doing an adequate job. They have very few clients and do not put forth any effort. Therefore we drop them and ask patients to attend the nearest clinic.

Many of the TBAs are able to cycle which helps them attend to their clients more rapidly. We have one TBA who owns a scooter. She has the highest number of new acceptors. In addition to her TBA duties, she
is a broker and matchmaker as well. She not only contacts the women but usually she goes to the husband or mother-in-law. In Asian countries mothers-in-law and husbands play an important role in the family. Another very active TBA makes her contacts at social gatherings such as weddings, birthday parties, or other feasts. She carries her supplies with her at all times.

The project was started in Kelantan in September 1972. The aim of the project is to utilize TBAs for family planning services in rural areas without adequate health facilities.

The Ministry of Health had registered most of the TBAs and both the Ministry of Health and the National Family Planning Board jointly conducted courses for some of the TBAs. They were instructed on safe deliveries and family planning, and were given a UNICEF bag containing some items required to assist at childbirth.

In 1972, 32 trained and registered TBAs were given additional training in family planning (e.g. motivating eligible women, supplying contraceptives, and identifying defaulters). After 6 months 14 were dropped from the program because they did not recruit any acceptors.

In mid 1974 there were 18 active TBAs in Kelantan state distributed as follows: Pasir Mas 4, Pasir Puteh 2, Jerteh 1, Kuala Krai 2, Machang 3, Bachok 2, and Kota Baru 4. They recruited 689 new acceptors with 21 being NFPB defaulters recruited by TBAs, 260 defaulters after being recruited by TBAs, and 459 revisits.

She commands high respect in her area of operation (usually one or two rural villages) and is known to everyone. TBAs are usually elderly people with many years of experience. Her care of the patient is very much a motherly form of attention. She follows certain customs and beliefs of the rural population (e.g. massages, dispensing local medicines, and performing abortions when desired).

In attending a patient, she stays with the patient for a few days even after delivery.

The TBA sets no time limit when attending a patient. She stays with the patient for a few days even after delivery.

Problems

The TBAs have to be told regularly how to maintain coupons and pills, and occasionally do not follow the appointment dates at clinics.

They rarely get new acceptors from their delivery cases and there is a danger that the TBA dropouts will spread false rumours about the project.

Conclusions

The NFPB staff supervising the project in Kelantan are carrying a heavy load. In dealing with the TBAs and in servicing and revisiting the 700-plus acceptors, there is considerable work in recording, paying TBAs, instructing TBAs, and so on. More supervisory staff will be required in the near future.

The Kota Baru Experience

WAN KHADIJAH BINTI WAN HUSSAIN

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More frequent refresher courses, at least every 6 months, would help maintain interest and morale of the TBAs. Bonuses for outstanding performance should be increased, and TBAs with a very poor performance record should be dropped from the program. Program staff should be sent on seminars and study tours occasionally to broaden their experience and effectiveness in the program.