Role of Traditional Birth Attendants in Family Planning

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Contents

FOREWORD 5

OPENING ADDRESSES 7

PARTICIPANTS 13

SESSION I PAPERS — Traditional Birth Attendants:
Facts and Scope, National Experience
Chairman: Prof Chindabha Sayanha-Vikasit

• Traditional Birth Attendants in Indonesia,
  Subagio Poerwodihardjo, MD  17

• Traditional Birth Attendants in Malaysia,
  J. Y. Peng, MD  21

• Traditional Birth Attendants in the Philippines,
  Flora B. Bayan, MD, MPH  23

• Traditional Birth Attendants in Thailand,
  Winich Asavasena, MD, MPH  27

Discussion Summary, Dr J. Y. Peng (rapporteur) 29

SESSION II PAPERS — Implementation of Programs
Chairman: Amansia Angara, MD, DPH

• Implementation of Family Planning Program in Malaysia,
  M. Subbiah, MD, MPH  33

• Implementation of Family Planning Program in the Philippines,
  Amansia Mangay-Angara, MD, DPH  37

• Implementation of Family Planning Program in Bali,
  I. B. Astawa, MD  41

• Implementation of Family Planning Program in Thailand,
  Srisomang Keovichit, MD, and Chalam Nomsiri, MD  43

Discussion Summary, Ms Aurora Silayan Go (rapporteur) 50

SESSION III PAPERS — Problems Found and Lessons Learned from the Operation
Chairman: Soebagio Poerwodihardjo, MD

• Problems and Findings from the TBA Program in the Philippines,
  Fe del Mundo, MD  55

• Problems and Findings from the TBA Program in Thailand,
  Udom Vejamon, MD, MPH, and Ravivan Sangchai, BSc, BED  61
Problems and Findings from the TBA Program in Indonesia, R. Wasito, MD 65

Problems and Findings from the TBA Program in Malaysia, Matron Hajjah Zaharah bte. Abdullah 69

The Malacca Experience, Kua Eng Lan 70

The Kota Baru Experience, Wan Khadijah binti Wan Hussain 72

The Perlis Experience, Lim Kim Goey 73

Discussion Summary, Dr Bachtiar Ginting (rapporteur) 74

SESSION IV PAPERS — Outlook and Research for the Future
Chairman: M. Subbiah, MD

• Outlook and Future Research in the Thailand TBA Program (Part 1), Chaichana Suvanavejh, MD, MPH, MSPH, and Pensri Phijaisanit, MD, MPH 79

• Outlook and Future Research in the Thailand TBA Program (Part 2), Pensri Phijaisanit, MD, MPH 83

• Outlook and Future Research in the Indonesian TBA Program, Bachtiar Ginting, MD 87

• Outlook and Future Research in the Malaysian TBA Program, J. Y. Peng, MD 89

• Outlook and Future Research in the Philippines TBA Program, Aurora Silayan Go 95

Discussion Summary, Dr T. Mayhandan (rapporteur) 98

SESSION IVa — Discussion Reports and Final Recommendations

• Epilogue 99

• Group I Discussion, Dr T. Mayhandan, rapporteur 101

• Group II Discussion, Dr Flora B. Bayan, rapporteur 102

• Group III Discussion, Ms Aurora Go, rapporteur 105

• General Recommendations 107
Implementation of Family Planning Program in Thailand

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Thailand (Fig. 1), as well as other Asian countries, has recognized the need to use the traditional birth attendants in rural areas where qualified health personnel are not available. To study this need and recognizing the important role of TBAs in rural communities, the Faculty of Public Health and the National Family Planning Board (NFPB) launched a pilot project in the central region of Thailand with the financial assistance of the International Development Research Centre.

Objectives

The objectives of this program are: 1) to apply alternative types of work situations, with and without incentives, in an attempt to induce change in behaviour of TBAs; 2) to evaluate the various types of work situations and to assess the most likely approach to the use of TBAs as a motivator to encourage eligible women in rural areas to accept family planning; 3) to make recommendations to the Ministry of Public Health as to how best TBAs can be utilized.

Areas Studied

The four areas studied were selected at random (Fig. 2). The basic unit of the study was an ampur (district). They are 1) Nakorn Nayok (Ampur Ban-Na); 2) Kanchanaburi (Ampur Ta-Muang); 3) Petchaburi (Ampur Ban-lard, Ampur Ta-Yang); and 4) Chantaburi (Ampur Khling, Ampur Lam-Singha).

According to the criteria of area selection, each must have at least 30 TBAs, otherwise the adjacent areas were included on random basis. Therefore in Petchaburi and Chantaburi two ampurs in those provinces were selected.

Subjects Studied

We studied the TBAs, eligible women, and community leaders (Table 1). The study of eligible women in areas where TBAs were working was carried out to determine how TBAs can get the information to them. We recognized, of course, that the women can be swayed by other sources of information, which is frequently inaccurate.

Three approaches were tested in the four areas (Table 2). The study included a pretest-posttest control group (Fig. 2). All subjects were interviewed for baseline information, then the different approaches were applied to each area. After one year the
operation will be evaluated by interviewing all subjects.

Program Operation

The implementation and operation of this program required three phases:

Phase I

1 Contact the local health workers of four areas, informing them about the objectives, how the program will be performed, developing a good relationship, and obtaining a list of TBAs and local community leaders.
NAKORN NAYOK

TBA → Interview → 4 day Training → Operation → Incentive → Interview

Community Leader → Interview → 1 day Training → Operation → Interview

Eligible Women → Interview

KANCHANABURI

TBA → Interview → 4 day Training → Operation → Incentive → Interview

Eligible Women → Interview

PETCHABURI

TBA → Interview → 4 day Training → Operation → No Incentive → Interview

Eligible Women → Interview

CHANTABURI

TBA → Interview → 4 day Training → Operation → No Incentive → Interview

Eligible Women → Interview

CONTROL GROUP

TBA → Interview → 4 day Training → Operation → No Incentive → Interview

Eligible Women → Interview

Figure 2. Approaches tested in the four areas, including a control group.

2 Contact the local district officer to get the list of eligible women.
3 Prepare and pretest the questionnaire for the field operation.
4 Train the interviewers and supervisors in the field.
5 Prepare all facilities for field operation.

Phase II
1 Interview TBAs, eligible women, and local community leaders.
2 Train TBAs and community leaders (Appendix 1).
3 Distribute coupons to TBAs (Appendix 2).
4 Make incentive payments to TBAs in Nakorn Nayok and Kanchanaburi (Appendix 3).
5 Develop refresher courses for TBAs and community leaders 4 months after the initial training (Appendix 1).
6 Supervise local health personnel in record keeping and filing.
7 Re-survey conducted for TBAs, community leaders, and eligible women.

Phase III
Evaluation of the program based on three criteria: 1) the behavioural changes of TBAs and the community leaders; 2) the behavioural changes of the public (eligible women); and 3) the number, characteristics, and continuation use of contraceptive methods of acceptors recruited by TBAs.

Demographic Characteristics of TBAs
The results of the interviews of TBAs can be summarized as follows: All are female; the mean age is 56.5, range 40–74 years; all were married (about half widowed); 90%
TABLE 1. Total number of TBAs, eligible women, and community leaders in four areas.

<table>
<thead>
<tr>
<th>Area</th>
<th>No. of TBAs</th>
<th>No. eligible community leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nakorn-Nayok</td>
<td>32</td>
<td>350</td>
</tr>
<tr>
<td>Kanchanaburi</td>
<td>30</td>
<td>300</td>
</tr>
<tr>
<td>Petchaburi</td>
<td>38</td>
<td>308</td>
</tr>
<tr>
<td>Chantaburi</td>
<td>36</td>
<td>305</td>
</tr>
</tbody>
</table>

The mean age of the community leaders was 43.4 (range 29–50 years); 76% had 4 years of education, 12% had higher than 5 years, and 12% had no schooling; the main occupation was farming; 100% of them had a favourable attitude toward family planning (the main reason being the economic burden); the average number of birth control methods known by community leaders was 6.8 (the most popular being vasectomy, oral pill, IUD, and tubal ligation); and 48% were practicing birth control at the time of survey.

TABLE 2. Approaches given to four areas.

<table>
<thead>
<tr>
<th>Training</th>
<th>Incentive</th>
<th>Working with community leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
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<td>No</td>
<td>No</td>
<td>No</td>
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</tbody>
</table>

TABLE 3. Ratio of active TBAs and acceptors of family planning by month in four areas.

<table>
<thead>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nakorn-Nayok</td>
<td>1.5</td>
<td>2.3</td>
<td>2.0</td>
<td>9.0</td>
<td>4.0</td>
<td>2.2</td>
<td>1.9</td>
<td>2.5</td>
<td>1.9</td>
<td>2.4</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Kanchanaburi</td>
<td>–</td>
<td>1.0</td>
<td>1.0</td>
<td>1.6</td>
<td>1.0</td>
<td>1.0</td>
<td>0.7</td>
<td>1.0</td>
<td>2.0</td>
<td>0.8</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Petchaburi</td>
<td>–</td>
<td>–</td>
<td>2.0</td>
<td>0.8</td>
<td>2.0</td>
<td>–</td>
<td>2.6</td>
<td>0.8</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Chantaburi</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
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</table>

Role of Community Leaders

The local community leaders are elected by the villagers to be the head of the village. They are always men. This program included 25 community leaders from Ampur Ban-Na and Nakorn Nayok. They were also given a one-day training program in population and family planning including methods of birth control (Appendix 1).
women who cannot afford to pay for the clinic service charge to get free service.

**Discussion**

The evaluation of the program has not yet been completed. However, according to the available data and observations the following preliminary observations can be made:

1. **TBAs can be trained to be a motivator in family planning:** In this program only one third are active motivators, age being one of the limiting factors.

2. **The training program:** The effective training program should be no more than 5 working days, since TBAs have other responsibilities. The method of teaching should be very simple and informal. Questions and answer periods are the most effective methods. The local language should always be used. The atmosphere should be lively, friendly, and sympathetic. Certain teaching materials stimulate more interest to learn, particularly movie film showing the local story on family planning (Appendix 1).

   Periodic refresher courses are needed. Since TBAs are older people they tend to forget very easily. The refresher course should be about 4–5 months from the initial training program. On the other hand, this course can serve to correct any misunderstandings of the subject.

3. **Relationship of TBAs and the Local Health Worker:** To obtain the most effective FP program in the community, we must develop close cooperation between the health worker and the TBAs.

4. **The role of local community leaders:** The local community leaders with high social prestige in the society can create awareness for family planning needs and refer women to the TBAs.

5. **The number and characteristics of acceptors:** In this study there are four approaches made by TBAs in different areas. The total number of acceptors is highest in the group where all kinds of attempts had been tried. The area in which the incentive was given was no better than in the group not given an incentive. In the group that received training the number of acceptors was higher than in the group that had been given training and an incentive (Table 3).

   If we consider the ratio of active TBA to acceptor, the best group was in Nakorn Nayok. In the Petchaburi group (only training was given), the number of acceptors was second.

**Acknowledgments**

The authors would like to acknowledge the contributions of Professor Tongchai Papasarathorn, Dean of the Faculty of Public Health; Professor Chindabha Sayanavikasit, Head, Department of Maternal and Child Health; Dr Winich Asavasena, Director of the Division of Family Health, Ministry of Public Health; Dr Charas Yamarat, Director of the Institute for Population and Social Research; Dr A. G. Rosenfield and Dr J. O. Alers, Population Council; and Dr R. G. Burnight, Consultant for the Institute for Population and Social Research for valuable advice. We are also highly indebted for the excellent cooperation of Dr Udom Vejamon, Director of the Banna Health Centre, Nakorn Nayok Province; Dr Punya Reunvongsa, Provincial Health Officer of Chantaburi Province; Dr Chitti Choavullee, Provincial Health Officer of Kanchanaburi Province; Dr Suchart Chandrabunchop, Provincial Health Officer of Petchaburi Province; and all local health personnel in these four provinces who helped us communicate with the TBAs and the villagers. We also would like to thank those TBAs and the eligible women who were interviewed as well as the community leaders for their cooperation in answering our questions. Their contributions to our research, although anonymous, are vital and important. We are most grateful to the International Development Research Centre, particularly Dr John Gill and Dr John Friesen, for their kind help and valuable advice.

**References**

The training course included a variety of topics during the 4-day period. Teaching methods were informal lectures, group discussions, question and answer sessions, and demonstration and use of audio-visual aids (e.g. model, flip chart, slide and movie projection).

The opening session was performed by the Ampur Head. This gave the trainees a feeling of being accepted by the local official as a member of the health team.

The trainers were from the Department of Maternal and Child Health, Faculty of Public Health, Mahidol University, the NFPP, Ministry of Public Health, and the Provincial Health Office.

The training atmosphere is lively during the program, and the trainers and the trainees enjoy each other very much.

The teaching methods were informal lectures, with simple terms. The lectures were interrupted frequently by TBAs asking questions. TBAs were particularly interested in the demonstration of audio-visual materials.

Session 1 General family health problems
Session 2 Population problems related to health problems
Session 3 Review of physiology and anatomy of reproductive organs
Session 4 Problems of delivery in rural Thailand and demonstration of home delivery
Session 5 Methods of birth control, indication, effectiveness, and contraindication
Session 6 How to select the women to get the service and how to work cooperatively with the village leaders and local health workers
Session 7 How to motivate people to adopt family planning and service role of TBA in family planning
Session 8 The advantages of family planning being integrated into MCH, and how to distribute coupons.

A one-day refresher course for TBAs was needed to emphasize and correct misunderstandings about contraception. The course focussed on questions from the TBAs and the trainer gave the correct answers or helped them to solve the problems.

A one-day training course for the community leaders was held in the health centre at the same time as the TBAs. One doctor and one nurse gave informal lectures. A movie film and exhibition of contraception were shown and these were of considerable interest to the leaders.

A one-day refresher course for the community leaders was offered after the refresher course for the TBAs. This course focussed on the methods of birth control and side effects as well as rumours about the different methods in the community. The method of teaching was mostly through questions and answers.
Appendix 2

Coupon for TBA Study

Referral Card

NFPP
Ministry of P.H.
No. ........................................

I.D. No. of Mohtamyae ..................................................

For your family health: If you want to space your children or do not want any more children, please bring this card to get family planning service at any hospital, health centre, or midwifery centre in your area.

For F.P. Worker please provide special service to the bearer of this card who had received information from research project of Mahidol Univ. and NFPP. Fill in the information below and send to the NFPP not later than the fifth day of the month. Thank you.

Name of acceptor ..........................................................
Address .................................................................
Place of service ........................................................
Method of Birth Control.
Date .................................................................

☐ IUD  ☐ Vasectomy  
☐ Pill  ☐ Tubal ligation  ☐ Other

A coupon system was developed whereby each time the acceptor came to the clinic, she was to bring a coupon from her TBA. This also served as a check on the activities of the TBAs.

Appendix 3

Incentives Given to TBAs

If TBAs can motivate a woman to adopt family planning, she will receive 10 bahts (Can. $0.50) per new acceptor. Incentives are given on the initial visit, the second visit, and the third visit. The incentive for IUD (at the time of insertion) is 5 bahts, 1 month later 3 bahts, and 6 months later 2 bahts. The incentive for recruiting pill acceptors (at the first cycle) is 2 bahts, 1 month later 3 bahts, and 3 months later 5 bahts.

For vasectomy and tubal ligation, the TBA receives 10 bahts immediately, because these are permanent methods of birth control.

Paying incentives in this way encourages the TBAs to bring the acceptor in initially and continue to motivate new acceptors. If the TBA cannot convince a woman to continue using a birth control method for a given period, she will get only a part of the 10-baht incentive.