

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

Cosponsored by the

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- NATIONAL FAMILY PLANNING BOARD, MALAYSIA

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Foreword

The United Nations declared 1974 "World Population Year." Attention is being focussed by health workers and policy makers on family planning on a global scale, but particularly in developing countries where the population growth is highest. The governments of most Southeast Asian countries are now officially in favour of family planning, and infrastructures within appropriate ministries are being developed to carry out programs.

One potentially important source of promoting family planning is via the Traditional Birth Attendants (TBAs). This seminar was organized to study the utilization of TBAs in family planning programs. The TBAs (mostly women in their 40s and older) are often highly respected in their communities and could be successful in motivating large numbers to adopt family planning. Mobilization and utilization of this large group of people (over 100,000 in the four countries of Malaysia, the Philippines, Indonesia and Thailand) will require careful study of the methods needed to train and supervise their actions. This is particularly important if TBAs are to dispense contraceptives (after initial issue by qualified health workers). Malaysia has developed systems incorporating the latter that seem to be working well.

The opening session was chaired by Dean Tongchai Papasathorn of the Faculty of Public Health, Mahidol University. In his opening remarks, Dr Tongchai said: "I would like to welcome all participants from Indonesia, Malaysia, the Philippines, and Thailand. It is a great honour for us to have all of you here to contribute to this seminar for the mutual benefit of family planning programs in this part of the world." He also expressed gratitude to the Rector of Mahidol University, Professor Kasarn, for his strong support. The assistance from the International Development Research Centre, the help provided by Dr J. Y. Peng of WHO, and the generosity of UNICEF for providing the meeting room facilities was also noted. The text of the opening addresses by Professor Kasarn and Dr Manasvi Unhanand, the Deputy Under-Secretary of State for Public Health, Thailand, follows this Foreword. The final speaker during the formal opening sessions was Dr John Gill of IDRC. Dr Gill spoke briefly

saying how pleased IDRC was to support the work being done at Mahidol on the utilization of TBAs in Thailand, and to help support this seminar. Dr Gill stated that the important question to be answered by the participants was: Is there a future role for TBAs in family planning? If the answer to that question is positive, then how do we harness the capabilities of this cadre of personnel?

The seminar was a "travelling" type, with the official opening and initial sessions being held at UNICEF headquarters in Bangkok, Thailand. The participants made a field trip to a Thailand Family Planning Project at Nakorn Nayok before travelling to Penang for two field trips (to Kedah, a Malaysian Family Planning Project, and a visit to a Family Planning Service in Penang). The group reconvened for a final one-day discussion session in Kuala Lumpur to assess the seminar and to formulate recommendations for further research.

The papers are included in the Proceedings in the order they were presented at the Seminar. There were four sessions as follows: 1. TBAs: Facts and Scope, National Experience; 2. Actual Implementation of Programs; 3. Problems found and lessons learned through the operation of programs; 4. Outlook and research for the future.

After each group of session papers we have included the Summary of Discussion of that Session prepared by a rapporteur/participant. The wrap-up summaries of the three Discussion Groups and Final Recommendations are included after the last paper.

This seminar was cosponsored by the International Development Research Centre, the Faculty of Public Health of Mahidol University, and the National Family Planning Board of Malaysia. The cosponsors hope that the seminar and this publication will be significant contributions to "World Population Year."

J. Y. PENG
SRISOMANG KEOVICHIT
REGINALD MACINTYRE
Editors

Opening Addresses



The official opening of the seminar (left to right): Dean Tongchai, Dr. Kasarn, and Dr. Komol

Professor Kasarn Chartikavanij

Rector, Mahidol University

It is a privilege and great honour for me to speak on the occasion of this Seminar on the Role of Traditional Birth Attendants in Family Planning.

In our country, as well as other Asian countries, the delivery of health care services in rural areas is still conducted by the traditional health practitioners, particularly in the field of Maternal and Child Health. There are many studies which confirm that about 60-80% of deliveries in rural areas are made by unqualified persons, such as traditional midwives, husbands, and relatives. Out of this total, 60% of births are delivered by traditional midwives or "Mohtamyae." Realizing this problem, the Ministry of Public Health had in the past provided training programs for Mohtamyae with the assistance of UNICEF. At the present time, another role of Mohtamyae should be considered and that is to assist the local government health workers in the family planning program, since this is a part of maternal and child health service. The Faculty of Public Health with the cooperation of the National Family Planning Program is conducting a study concerning the utilization of Mohtamyae as a motivator in family planning. I hope, therefore, in this seminar you can all share experiences and knowledge learned from each other and make a useful contribution for a future successful family planning program in our Asian countries where the problems are similar.

On behalf of Mahidol University, I would like to express our sincere gratitude to the International Development Research Centre for making this seminar possible, and to welcome all delegates from Indonesia, Malaysia, Philippines, and Thailand, and also thank all those who have assisted in the arrangement of this seminar, particularly Dean Tongchai. I do hope that the outcome of this seminar will be of great benefit to the family planning programs in this part of the world.

In conclusion, it is a pleasure to declare this seminar open and I believe that it will be an outstanding contribution from Thailand and Malaysia to mark the World Population Year.

Dr. Manasvi Unhanand

Deputy Under-Secretary of State for Public Health

On behalf of the Ministry of Public Health, it is my pleasure to extend to all of you the most cordial welcome to Thailand and to wish you a pleasant stay in our country.

The socioeconomic and public health implications of rapid population growth are challenges we in Southeast Asia have taken up with great earnestness. It is gratifying to see that the countries represented at this seminar have launched their national family planning programs, and have already made considerable progress toward their objectives and targets. However, there are still many constraints to the development of more effective national family planning programs. One major constraint is the serious shortages of medical personnel in rural areas. Despite the extremely low physician-population ratio in rural areas of most countries in Southeast Asia, the most effective family planning methods are usually required by law to be prescribed or administered only by physicians. As a result, the family planning services do not now reach a majority of the rural population, and will not in the near future. In Thailand, for example, despite the fact that auxiliary midwives are allowed to prescribe the oral pill, Thailand's National Family Planning Program has suffered a decline in oral pill acceptors. Since two thirds of the total acceptors in Thailand are oral pill acceptors, the further decline in oral pill acceptors will seriously hinder progress toward the 1976 target of a 2.5% population increase rate. It is obvious that new approaches are necessary, and these must be implemented quickly.

We are approaching this situation in several ways. First, we hope to add two new methods, the condom and Depo-provera, by the end of this year. Both will be added to the existing family planning service outlets, with the Depo-provera reserved for those outlets with close medical supervision. Second, we are exploring new uses of existing personnel in delivering family planning services. A project using nurse-midwives to insert IUDs is the final stage of evaluation, and

we will begin a pilot project using auxiliary midwives to administer Depo-provera this year. The Planned Parenthood Association of Thailand is exploring ways of promoting vasectomy, an under-utilized family planning method in Thailand. Third, we have started the motivation campaign by using mass media, commercial resources, folk entertainers, and mobile information units equipped with sophisticated audio-visual aids. Fourth, we are looking into the possible use of indigenous people in the motivation of couples and also in delivery of family planning services. Among these indigenous people are village headmen, school teachers, shopkeepers, hair-dressers, bus drivers, satisfied acceptors, and traditional birth attendants (TBAS), the subject of this Seminar.

After reading the preliminary report on the study of utilization of TBAS in the family planning program in Thailand, it seems that, in the four pilot areas in Thailand, they have not met our high hopes for them as family planning motivators. Only half of the study group were active in the first 10 months. The number of acceptors is small and the continuation rate for pill acceptors is less than 40% at 7 months. The final report, however, is yet to come, and may show better results.

One of the objectives of this Seminar is to share knowledge and experience. We look forward to your comments and suggestions on the results of our efforts to induce TBAS to participate in the family planning program. This will help us interpret the somewhat disappointing results to date and tell us how to improve our approach.

On behalf of the Ministry of Public Health, I would like to take this opportunity to express my sincere appreciation to the International Development Research Centre, the National Family Planning Board of Malaysia, and Mahidol University, whose assistance and cooperative efforts have made this Seminar possible. I also wish to extend my thanks to all the participants for coming to attend the Seminar, because without your participation this Seminar would not have been possible.

Ladies and Gentlemen, may I extend to all of you my very best wishes for the success of this Seminar and for the fruitful results that will follow in the near future.



The seminar participants outside the home of a TBA in Malaysia

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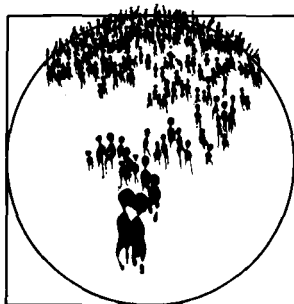
Session I Papers

Traditional Birth Attendants: Facts and Scope, National Experience

Chairman: Prof Chindabha Sayanha-Vikasit



" . . . about 60-80% of deliveries in rural areas are made by unqualified persons, such as traditional midwives . . . " (Prof Kasarn in his opening address)



Traditional Birth Attendants in Indonesia

SUBAGIO POERWODIHARDJO, MD

*Director, MCH and FP Division
Ministry of Health, Jakarta, Indonesia*

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 co-operation 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 Samporno 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:

DKI Jakarta Province	100
West Java Province	2,625
Central Java Province	6,750
DI Yogyakarta Province	405
East Java Province	4,500
Bali Province	-

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.

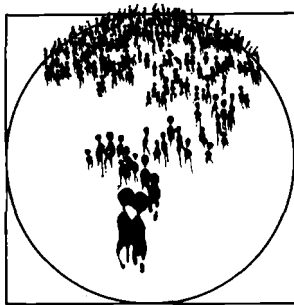
It is important to realize that because of her position within the community, particularly in rural areas, TBAs may become obstacles to the program. Therefore, it is strongly recommended that efforts be made to secure at least the passive endorsement of the program by the TBAs, even if their active cooperation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

The Future

Assuming that a TBA 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 TBA project should be handled by an agency set up for the purpose, and evaluation should be conducted on an on-going basis.



Traditional Birth Attendants in Malaysia

J. Y. PENG, MD

*World Health Organization
Kuala Lumpur, Malaysia
and University of Michigan
Ann Arbor, Michigan*

THERE are an estimated 3000 traditional birth attendants (kampong bidans) in Malaysia. The Ministry of Health started to register these TBAs a few years ago and by the deadline date some 1888 had officially registered.

In January 1969 the National Family Planning Board and the Ministry of Health of Malaysia started to train these TBAs for 3 weeks including 1 week for maternity care, 1 week for family planning, and 1 week for actual experience with local health authorities. UNICEF assisted the training project and one of the UNICEF delivery kits was given to each TBA who completed the training. No systematic plan was adopted to utilize the TBAs in health or family planning. They were requested to record the delivery cases and report to the local health authorities, bringing the midwifery kit to be examined by the nurse/supervisor, and to get a supply of consumable items.

Some effort has been made to compile information about TBAs in Malaysia, such as: the actual number, their background characteristics, the customs they follow related to childbirth, the proportion of deliveries being attended by the TBAs, how are they trained to practice, how much do they charge for

attending each delivery, what is their attitude toward family planning, can they be utilized in health and family planning programs, etc.

Childbirth Customs

Professor Paul Chen (1973) of the University of Malaya has done some research on the customs related to childbirth in rural Malay culture. He summarized the customs related to childbirth as practiced by rural Malays into four categories: The *beneficial*, such as prolonged breast-feeding, restrictions on the activities and movements of mother and baby, and a local postpartum massage, should be actively encouraged or adopted. The *harmless*, including measures devised against evil spirits, are best ignored. The *harmful*, such as dietary taboos, will require modification by friendly persuasion and health education. Those of *uncertain* effect, including the customary "roasting" of the mother, need to be further investigated.

Survey of TBAs

Information relating to other questions was obtained through interview of the TBAs at the time they came for 3 weeks' training. The interviews were conducted between January 1969 and December 1970 and the

results were published in "Studies in Family Planning" in February 1972 (Peng et al.). Although the interview sample was 292 and not scientifically selected, and hence not representing the universe, the results were quite useful for general information. The mean age of the TBAs was 47, ranging from 20 to 71. About 84% of them were over 40. About 73% were currently married, 18% widowed, 8% divorced or separated, and 1% never married.

Eighty percent had no schooling and 18% had only 1-5 years education. Forty-three percent had practiced less than 10 years, 32% between 10 and 20 years, and 25% more than 20 years.

When asked who taught them to deliver babies, 27% said their grandmother, 22% their mother, 8% their aunt, 5% their friend, 2% mother-in-law, and 6% combination of people mentioned above, and 30% other sources.

On average, each TBA reported attending three deliveries during the past month and 26 deliveries during the past year. TBAs with more years of practice had the higher average number of deliveries attended.

The average charge reported by them was 5.4 Malaysian dollars (about US \$2) per delivery. Thirty-six percent said they did not receive gifts other than cash but the other 64% said they received clothes, chickens, and other items.

Fifty percent said that they performed massage combined with other services, and 12% said they did not do anything other than midwifery tasks.

Almost 100% of the TBAs approved of providing married women with family planning services. Ninety-nine percent said that they were not worried that the government's family planning services would affect their job in conducting deliveries. Ninety-five percent thought that they could help to promote the government's family planning program

by recruiting acceptors and distributing contraceptives.

According to a report by the Maternal and Child Health Committee of the National Health Council, about 174,000 births or 57% of all deliveries in 1964 were under medical supervision (through government hospitals, health centres, non-government nursing homes, and clinics at rubber estates and tin mines). The remaining 43% of all deliveries were attended by private midwives almost all of whom were TBAs. According to the West Malaysian Family Survey conducted in 1966-67, 39% of rural and 31% of all respondents' last live births were attended by TBAs.

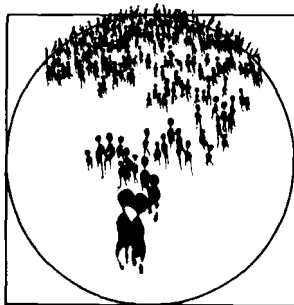
Future Role of TBAs

There are still some more important questions to be answered. Is there a place and value in utilizing these traditional birth attendants in family planning or in health services? If so, how long can the TBA be of use considering the development of health manpower and facilities in the country, and how do we secure financial resources to maintain the program?

In Malaysia we organized the TBAs to utilize them in the national family planning program. We think we have done a good job in this field in Malaysia with a well-organized system of operation and close supervision.

References

- CHEN, P.C.Y. 1973. An analysis of customs related to childbirth in rural Malay culture. *Tropical and Geographical Medicine*, vol. 25.
- MATERNAL AND CHILD HEALTH COMMITTEE. 1965. A study of the maternal and child health service in the states of Malaysia. National Health Council, Kuala Lumpur.
- NATIONAL FAMILY PLANNING BOARD. 1968. Report on West Malaysian family survey 1966-1967. Kuala Lumpur, Malaysia.
- PENG, J. Y., NOR LAILY BTE. A. BAKAR, AND ARIFFIN BIN MARZUKI. 1972. Village midwives in Malaysia. *Studies in Family Planning*, vol. 3, no. 2, February.



Traditional Birth Attendants in the Philippines

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ON-GOING population programs in this and other regions have diverging strategies to suit prevailing conditions and resources. Critics have cautioned family planning program administrators that unless they try to understand first the values and goals of the people who are the consumers of family planning services, the desired results may not take place. It must be added, however, that the individual values and goals as perceived by the consumers and by all program communicators deserve equal, if not more, important consideration to complete a positive and meaningful cycle of action and interaction for social change. Others have suggested that because of several built-in biases in the social milieu, which remain unrecognized, saturating a country with family planning clinics would not expose significantly the pregnancy-risk-age women to such programs and would hardly produce discernible results. Some view the public health approach as unrealistic for one or both of the following reasons: a) the shortage of trained manpower in many developing countries; and b) the need to strengthen and expand the coverage of existing public health structures, the Maternal and Child Health and other basic health services. Other studies point out that probably more important than all this would be

for programmers and action workers to realize that many of the people still prefer a large family, that "planning" for size and giving consideration to desired number of children are ideas which have not yet become a way of life for most couples. These observations seem to indicate that attention to, and proper consideration of, the interplay of varying sociocultural and psychological factors will hasten the occurrence of social change. The internal perception of the occurrence of such change by the people themselves may be the determining factor in the success of family planning programs.

With this as general background, I will attempt to present some facts and findings about the "hilots" or TBAs in some parts of the Philippines. Admittedly, studies conducted on the characteristics of TBAs and their potential role in the national MCH/FP program are so scarce and inadequate that conclusions and recommendations for policy formulation regarding their recruitment and involvement have not yet been developed.

In the Philippines, TBAs have long been recognized as vital links in the delivery of health care, especially in the rural areas. Their presence in the barrio society has been a comforting assurance to the villagers and

rural residents who have daughters, daughters-in-law, and other relatives who have just delivered, or are about to deliver. The fact that the TBAs live among them means that he/she will be available to minister to their needs and to their complaints during pregnancy, labour, and delivery, and to help them during the critical postpartum period in looking after the newborn baby.

The TBAs may perform several key functions as birth attendants, as folk healers, or as masseuses. The same individual may devote herself to all three roles or may specialize in just one or a combination of roles. Some describe their services to include marriage advisor, family counsellor, and advisor and counsellor on sex matters. In other areas surveyed by IIRR, these local practitioners screen certain patients for referral to the medical practitioners. Many of them have established close and personal relationships with their clients and have lived in the same village for one or more generations. Their full utilization may yet provide the missing link in the chain of total delivery of health services to the remote barrios and villages.

Reasons for Becoming a TBA

How they acquired their specific knowledge in any of the roles they appear to perform is a matter of conjecture. In general, it is assumed that they have been taught by either their parents or grandparents, or both, and have "inherited" the talent for the vocation. The study of the Cebuano TBAs (Liu et al. 1970), however, showed that 5% interviewed cited a "supernatural" calling; 20% stated difficulties associated with their own births, while 7% stated a "dream" experience which had influenced or inspired them to pursue their calling.

The TBA as a Pronatalist

The motivation of potential FP acceptors depends to a large extent on the initial contact with the TBAs. Therefore, the TBA plays a critical role in influencing the parturient woman in regard to her reproductive behaviour.

Interviews of 61 TBAs and KAP studies of 2314 families, representing all social classes, which were undertaken in Cebu in the summer of 1969, revealed that 41% of the TBAs had six or more children. Thirty-eight percent said they would want the same number of children if they could start over again, and almost 20% would want an even larger family. Thirty-four percent of those who indicated a desire for more children wanted to increase their family size by five or more children.

Without implying that this would be the national trend, the findings suggest that in training the TBAs as health auxiliaries and/or family planning motivators, serious consideration should be given to individual values, personal biases including other factors which could influence their effectiveness, and credibility as sources of information for MCH/FP programs. Without sustained supervision, trained TBAs tend to revert to their old practices once they return to their villages. For instance, the use of gloves (sterile or unsterile) is practiced only by some of the respondents and, while 81% of the respondents bring scissors in their kits, only 49% actually use the scissors for cutting the umbilical cords. The rest use the traditional bamboo knife.

TBAs and Family Planning

When one considers that 70% of the people live in rural areas, with more than one quarter of the population dying without medical attention, and that 48% of reported births are attended by TBAs, the sudden introduction of modern medicine and technology presents a challenging situation for communication experts and family planners.

In the recruitment of lay motivators for the Family Planning Program, it was assumed that the TBAs, by virtue of their occupation and long direct contacts with mothers and children, would have the influence, local status, and ability to motivate postpartum patients and other potential family planning acceptors to practice family planning. Based on this premise, which was

later corroborated by Bautista (1972), the Family Planning Program initiated the involvement of TBAs as FP motivators in the pilot demonstration areas of South Cotabato, Albay, and Mindoro Oriental. The data indicated that they were able to refer an average of 27 acceptors per month compared with less than 20 referrals from the non-TBA motivators. However, 1½ years later the number of TBA motivators decreased as a result of the introduction of a more sophisticated reporting system requiring completion of a number of forms.

At present only those TBA-motivators with functional literacy have remained in the program. This limited trial on the utilization of TBAs for family planning showed that their involvement in the program calls for only the simplest and most practical approach. Sophisticated strategies in terms of training, recording, and reporting, and delivery of MCH/FP services have no place in the TBA program.

In the recently concluded WHO-sponsored consultation group for the Draft World Population Plan of Action (WPPA), the participants endorsed the recommendation for widening and expanding MCH/FP program coverage to rural, remote, and underprivileged groups. Achievement of such coverage calls for a phased expansion based on quantified objectives and carefully planned development of health services and distribution of resources. The following areas were emphasized: a) the use of non-professional personnel, including local residents, auxiliaries, and TBAs for primary level of care; b) their training in the use of screening procedures to identify need for referral for more expert care; c) supervision by an adequate ratio of supervisors to field workers and by selective rather than routine frequency of field visits

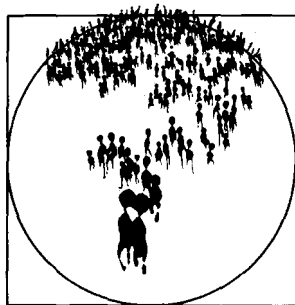
by supervisors; d) coordination between health and other agencies for use of common personnel, such as agricultural agents, as multipurpose workers; and e) meaningful community involvement.

Summary

The TBAs are respected and influential leaders in rural societies, and they possess great potential as auxiliaries in the delivery of health care. They can be guided toward positive roles in MCH/FP services through a carefully planned training program, with emphasis on the use of audio-visual methods of instruction and by demonstration techniques. As primary points of entry into the medical care system, they can be trained to serve as screening and referring agents. Sustained supervision is essential for maximum effective utilization of TBAs. To convert a group of pronatalists to become advocates and promoters of family planning will require a multidisciplinary approach, one that will penetrate the invisible wall of prejudice, bias, and other deeply ingrained attitudes which are inconsistent with, and resistant to, change.

References

- LIU, WILLIAM T., ARTHUR J. RUBEL, AND VIRGINIA PATO. 1970. The Cebu Family Health Project. Report on Selected Findings. Center for the Study of Man in Contemporary Society, University of Notre Dame.
- BAUTISTA, PAULINA. 1972. Analysis of Case Studies on Family Planning Motivators. Abstracts of Technical Reports. UNFPA/UP-IMC/UNESCO Family Planning Communication Project, Quezon City.
- PHILIPPINE HEALTH STATISTICS (1970). 1972. Disease Intelligence Center, Department of Health.



Traditional Birth Attendants in Thailand

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ALTHOUGH modern medical services are now well known in Thailand, the rural population is still not adequately covered by the health services network. Thai mothers still feel unsafe at delivery, especially those in the lower-income group in rural areas (Table 1).

The figures in Table 1 are part of the findings from the "Young Child Study Survey" which was conducted by the National Economic and Social Development Board in 1973.

As in other developing countries, Thailand has a very limited number of qualified health workers in rural areas. The proportion of physicians to the total population of these areas is approximately 1:100,000. More than 80% of the population has to depend on paramedical personnel or traditional healers. The deliveries in rural areas are often attended by indigenous midwives (traditional birth attendants). The TBAs can usually do a good job on "normal" deliveries, but she is often helpless when complications develop.

There are extremely high rates of maternal and infant death associated with the large numbers of women delivered at home. The present mortality rate for mothers is estimated at 4-5 per 1000 live births, while the infant

mortality rate is probably closer to 85 per 1000 live births.

The Ministry of Public Health has plans to produce more auxiliary health workers to work in rural areas. Effort is also being made to mobilize all the local resources such as traditional healers and volunteers in the provision of health services. The TBAs are also being utilized. The number of TBAs in each province is not known, but there is at least one in every village.

TABLE 1. Feelings of mothers toward child delivery. (Source: Young Child Study Survey, 1973, National Economic and Social Development Board.)

	Bangkok			
	Middle-income group	Low-income group	Other urban	Rural
	%	%	%	%
Dangerous (possibly fatal)	48.1	75.8	63.6	67.2
Dangerous (not fatal)	17.3	10.9	16.8	11.7
Naturally painful	32.7	13.3	18.2	19.9
No answer	1.9	—	1.4	1.2

Utilization of TBAs

Although there has been no nationwide study on the role of TBAs in rural Thailand, it is estimated that between 60 and 70% of all births are attended by them. There are approximately 1,000,000 births per year in Thailand. Of these, more than 800,000 are attended by TBAs or elderly relatives at home. Table 2 shows the preference of Thai women regarding different types of birth attendants. Obviously the TBAs still play an important part in maternal and child health in rural areas. And a large percentage of women (40%) still need their services at childbirth.

TABLE 2. Preference of Thai women regarding birth attendants and type of persons who delivered their last child (survey conducted in 1974). (Source: Research and Evaluation Section, NFPP.)

Type of birth attendants	% of women who preferred each type of birth attendant	% of women whose last delivery was conducted by each type of birth attendant
Health personnel	43.3	14.2
Husbands or other household members	7.2	11.5
Traditional doctors	0.5	0.6
TBAs	40.2	62.9
Friends or neighbours	1.1	1.8
Self delivery	4.5	6.4
Others	3.0	2.6

Some of the factors influencing the continuing need for the services of the TBAs are: a) their prominence in the community and their familiarity to the expectant mothers; b) clients do not have access to government services at a health centre or midwifery centre; c) clients do not have enough money to meet transportation and service costs for delivery at a hospital or health centre; d) home delivery facilitates the performance of necessary rituals marking the birth of the baby.

The age of the TBAs ranges between 35 and 79 and approximately 50% are over 50 years of age. About 60% of the midwives are illiterate, and 35% were trained by more senior TBAs. In one province, the TBAs have received in-service training by provincial health staff.

The Ministry of Public Health recognizes the role of TBAs in Maternal and Child Health, since most deliveries in the rural areas are being conducted by them. With UNICEF assistance, a training course has been conducted in various provinces during the past 15–20 years in an attempt to improve the care provided by the TBAs. This course lasts for 2 weeks. An emphasis is placed on sterile techniques, particularly in the handling of the umbilical cord and the newborn baby, plus some information on maternal and child health and nutrition. After completion of the course, each trainee receives a UNICEF midwifery kit. There are about 16,000 TBAs who have been trained under this program.

There is now an awareness of the necessity to include the TBAs in family planning programs, particularly as FP motivators. A project to evaluate various methods of inducing changes in the attitudes and behaviour of the TBAs toward FP and MCH is well under way.

Future Prospects

The Ministry of Public Health will continue to operate refresher courses for TBAs. Family planning will be integrated into the course so that the TBAs will feel obliged to provide family planning services as a part of their usual tasks.

As a follow-up, the nurse/supervisor of each province will supervise the activities of the TBAs, and establish any necessary reporting or referral systems.

Hopefully after completion of the pilot project recommendations can be made on how and to what extent the TBAs can be integrated into an MCH/FP program.

Discussion Summary — Session I

Rapporteur: Dr J. Y. Peng

- 1 Each country representative clarified the name of the traditional birth attendants emphasizing that it is never confused with names of other health workers, except for Thailand. The syllable "Moh" in the "Moh-tamyae" is frequently confused with the title "doctor."
- 2 There is a plan to evaluate the TBA project in Malaysia which will be carried out soon. The plan of evaluation will include interview of the TBAs, their supervisors' performance evaluation, such as number of acceptors recruited by the TBA, and continuation/resupply rate through the acceptor survey.
- 3 Most of the participants felt that their governments had accepted in principle the utilization of TBAs for MCH/FP though there still exists a negative attitude among doctors especially with regard to utilizing them in the distribution of oral contraceptives.
- 4 The future survival of the traditional birth attendants will probably depend upon the economic situation of the country concerned. Since the TBAs will be active for many years to come, the consensus was to join forces with them rather than attempt to eliminate them. The numbers of TBAs in each country was discussed, as were the ways and means of utilizing them in the provision of health services.
- 5 How far will individual governments be prepared to finance the TBA projects? There is no assurance that any country will provide financial support, except for the Malaysian Government Treasury which has approved M\$20,000/- as operative expenses toward the TBA project.
- 6 The general consensus was that the TBA should be utilized in a multi-purpose fashion (i.e. MCH as well as FP).

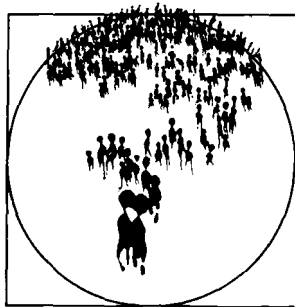
Session II Papers

Implementation of Programs

Chairman: Dr Amansia Angara



Here a TBA shows how she attempts to motivate women to adopt family planning



Implementation of Family Planning Program in Malaysia

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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

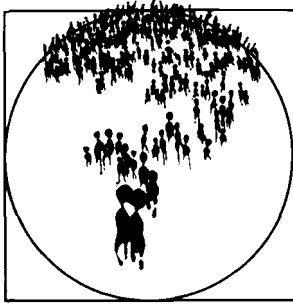
The expression of fertility in developing countries like Malaysia is the function of local cultural conditions and institutional patterns. In such a context, an effective motivation and communication process is significantly relevant. In exploring the possible channels of communication, our attention 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.



Implementation of Family Planning Program in the Philippines

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ONE basic function in the administration of local health services is to assess the kind of midwifery assistance available and to ensure that its utilization will help promote the welfare of both mother and child.

In the early 1950s the Department of Health examined the status of midwifery services in the Philippines and found: 1) a large proportion (about 75–80%) of the births were attended by “hilots” or traditional birth attendants (TBAs); 2) the infant and maternal mortality rates were comparatively high; about 100/1000 live births and about 3.8/1000 live births, respectively; and 3) the number of physicians, nurses, and midwives in the health services was grossly insufficient to meet the needs for midwifery services.

The large proportion of births attended by TBAs underscored the need for a policy decision on how the Department of Health should deal with the situation. To ignore the TBAs was unthinkable, and to eliminate them by regulation or law was unrealistic and not desirable, because of the limited official services available. The only alternative, therefore, was to train the TBAs and to integrate them to some extent into the health care system operated by the government. This positive step was formally declared to be an emergency measure to fill the gap while the government was undertaking the training of licensed mid-

wives. Thus, the Department of Health, with the assistance of WHO and UNICEF, started to teach TBAs in October 1954 as part of the country's midwifery training program. Training was first conducted for those who would be involved in teaching and supervision, such as the nurse-midwife supervisors at the central, then at the regional, and later at provincial and local levels. The program was further extended to the faculty of the schools of midwifery. The teaching content of the midwifery training program was designed to improve the preparation of the midwifery teachers, the supervisors of midwives, the practicing midwives, the student midwives, and the TBAs.

TBA Teaching

The government does not encourage TBAs to practice in localities where there are adequately trained persons who can provide maternal and child health (MCH) services. Training has been limited to actively practicing TBAs residing in rural areas who are over 40 years old. The program does not promote the training of new TBAs.

The objectives of the TBA teaching program are: 1) to make TBA practice less dangerous by teaching them (a) the importance of clean hands, (b) the use of clean equipment, (c) not to intervene, and (d) when to call for the help of the physician or nurse/midwife;

and 2) to bring TBAs gradually under the supervision of trained persons.

At the beginning, in order to place TBAs under supervision, supplies provided by UNICEF and government were given to replace those used by the TBAs; this motivated them to seek more contact with the health services. When, for budgetary reasons, supply replacement was later discontinued, the TBAs continued to maintain their contacts with the local health services and their supervision was continued through follow-up meetings.

The initial training of TBAs is conducted by a provincial nurse/supervisor who has been trained under the midwifery training program. Her understudy is the nurse or midwife of the rural health unit (RHU) or the puericulture centre (roughly the equivalent of an MCH centre), who ultimately becomes the teacher in subsequent TBA classes. There are 10 TBAs in each class. The course of instruction consists of 12 weekly meetings, each lasting about 3 hours. The instruction is conducted in the local language. TBAs receive UNICEF stipends to cover the cost of one meal and transportation expenses. On satisfactory completion of the course each TBA is given a UNICEF midwifery kit. After training, TBAs organize themselves into a local association and hold monthly follow-up meetings. They report their activities to the health centre. At these meetings the health centre staff inspect their kits and evaluate reports on their practices.

The "Instructor's Guide for Hilots Teaching" which was prepared by the Department of Health has been in use for nearly 20 years. Lately, this guide has been revised to include family planning. A very simple brochure, "The Good Hilot," has been developed and found very useful for TBA teaching. This is an audio-visual aid which can easily be prepared by the local nurse or midwife in any rural area.

From 1954 through 1973, over 9200 TBAs have been trained under the Department of Health TBA teaching program. Over 900 classes were conducted in all 70 provinces but one (Batanes, a group of islands in the

northernmost part of the Philippines) and in most cities of the country. Many provincial/city health officers, regional and provincial nurse supervisors, and rural health unit nurses and midwives have participated in TBA classes and follow-up meetings.

Midwifery Legislation

Midwifery training and practice in the Philippines is governed by legislation which restricts midwifery practice to only qualified personnel. There is nevertheless a provision in the law which states that "hilots registered with the Department of Health as having been trained in the art and practice of midwifery under the UNICEF-Philippine Department of Health Project and hilots in localities where the services of a practicing physician or registered midwife are not available... shall be allowed to continue in the practice of their trade." The law is rarely enforced because TBA practice and activities are sanctioned by tradition. There are TBAs because of community needs, especially in areas where the services of professionally trained personnel are not available.

The interest and demand for TBA services became manifest in 1972 when UNICEF temporarily suspended its assistance to the training of TBAs pending the evaluation of the training program. Provincial health officers filed urgent requests for the continuation of TBA teaching. Many municipalities proceeded with TBA classes and in a number of instances local government voted funds to pay stipends to the TBAs so they could continue their training.

Utilization of TBAs

While no large-scale or systematic assessment of the training and practice of TBAs has yet been done, some general comments and observations may be made on their utilization. The generalizations are based on a retrospective study presently being undertaken by the Division of Maternal and Child Health of the Department of Health. The study is based on the over 9200 TBAs who have been trained over the past 20 years and from field reports, interviews, and personal observations of TBA classes.

TBAS are not a homogeneous group. Their roles, practices, beliefs, characteristics, and attitudes vary from village to village. While their beliefs and practices may not be scientific, and may even seem strange, the underlying motives behind them are often unselfish. Some of their practices can be defined as harmless, although they may provide emotional support to the mother and the rest of the family so they should not be entirely disregarded. Their other practices, however, may be harmful to the health of the mother and the fetus, and some need to be modified or eliminated completely. Beliefs and practices connected with the traditional practice of midwifery in the Philippines are currently under study in the Department of Health with the assistance of an obstetrician and a sociologist.

In some cities and municipalities which have a favourable ratio of health personnel (and facilities) to population, the TBA practice has been eliminated. In many others having a high proportion of hospital births, a few TBAs who remain in practice limit themselves to only the traditional postnatal care of the mothers. The TBA makes a valuable ally to the rural health nurse or midwife attending births in the home: she fetches water, boils the instruments to be used, and assists the nurse/midwife and the family in a number of ways. She helps further by making postnatal visits to the mother and child until the baby's cord is off.

In most Philippine communities, TBA services are still sought, and when trained and supervised by rural health unit personnel, their performance is improved and their morale is good. Increasingly, TBAs are broadening their activities to include participation in the following community health activities: assisting in the recruitment and organization of mothers' classes; referring mothers to health centres for prenatal care; assisting in birth registration; helping in the round-up of children for immunization; helping in the housekeeping of health centres; assisting in motivating mothers toward family planning; following up family planning acceptors and

mothers and children who cannot be reached by the nurse/midwife in home visits; helping in the feeding centres; assisting in fund raising (e.g. selling tickets for health centre benefits); and participating in the census of families connected with medical care programs.

Current TBA Studies

Until very recently information on TBAs and on midwifery in general was limited. Although over 9200 TBAs have been trained in the government program over the past 20 years, the exact number in practice was unknown until 1974 when a nationwide survey, assisted by a WHO grant, was completed by the Division of Maternal and Child Health.

The study of TBAs is divided into three parts: identification and registration (1973-74); assessment of teaching (1974-75); and utilization in MCH and FP (1975-76).

The initial survey is to identify individually those TBAs in practice, and to define the extent of indigenous midwifery in the country. A directory or registry can then be prepared according to the political and administrative subdivisions of the country.

That survey will be followed by an assessment of the performance of trained and untrained TBAs in MCH, to provide the basis for formulating future training, supervision, and control activities.

Finally the study will endeavour to determine the extent that TBAs can be involved in MCH and FP. It will also help design and test alternative approaches to making TBAs more useful and effective.

Identification and Registration

This phase started in mid 1973. A series of orientation sessions for regional nurse supervisors, provincial nurse supervisors, and rural health nurses and midwives was conducted. A data collector (usually a rural health nurse or midwife) was designated for each of the 1500 municipalities in the country.

The study defines the TBA as a person who is usually called upon by the community to assist a woman during pregnancy, labour, and/or after delivery. The nationwide survey of all practicing TBAs was undertaken from October through November 1973, and was given cooperation by all regional health offices, provincial/city health offices, and the rural health unit personnel in the country. The survey results provide the material for the "National Hilot Registry" which was established in June 1974. We have now identified 31,200 practicing TBAs in the country (as of June 1974). Each TBA is given a code number and provided a card where such general information as name, address, sex, literacy, and education, etc. are noted.

The Registry is established in the Division of Maternal and Child Health. From this registry, duplicate cards will be made to compile local registries for the rural health unit of each municipality. The registry is used to identify and locate the TBAs for teaching or utilization in MCH and FP. The register is also a partial fulfilment of the requirements of the midwifery law.

Preparations for the second phase of the study are underway and will be followed by phase three.

Future Plan for Training

In view of the continuing active role of the TBA in midwifery practice the government, with UNICEF assistance, will reactivate the teaching program in 1975. The program has a target of 2000 trained TBAs in 1975. No stipends will be provided; a midwifery kit will be given each TBA upon completion of her training. Honoraria for teachers and supervisors will be provided.

The following estimates have been made on the number of TBAs for future training: of the 31,200 TBAs reported from the survey, about 6000 of the original 9200 who had been trained were still in active practice in 1973-74; the remainder of the trained group either died or are no longer in practice. Therefore, about 25,000 presently practicing TBAs have to be trained.

It has been proposed that 2000 be trained in 1975, 3000 in 1976, and 5000 each in 1977 to 1980 inclusive, with the continuing collaboration of UNICEF. The expectation is that toward the later part of this period, there would be enough physicians, nurses and government-trained midwives to provide needed health services despite the population increase.

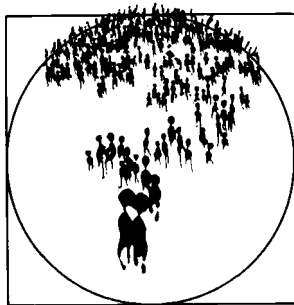
Conclusions

The role of the TBA in midwifery services in the Philippines continues to be significant. Although the number of births they attend has been decreasing over the years (75-80% of total births in 1954; 47% in 1972), the number of TBAs is still substantial considering the crude birth rate is about 40/1000 live births in a population of over 41 million people.

The maternal mortality rates have decreased from 3.2/100 live births in 1954 to 1.4/100 in 1972, or a reduction of 57%; for the same period, the infant mortality rates have decreased from 94/1000 live births in 1954 to 68/1000 in 1972, or a reduction of 28%. When it is considered that about one-half of the births are attended by TBAs, there is validity in assuming that the government program of teaching and supervising the TBAs has undoubtedly contributed to the decline in the mortality rates for mothers and infants.

The trend, which is supported by government policy, is to eventually replace the TBA services with those of the licensed midwives. There are 36 schools of midwifery which in 1973 graduated about 3500 midwives. In addition the seven schools of medicine and the 89 schools of nursing will provide future additional trained manpower.

What future is in store for the TBAs? Traditions die hard and perhaps for the next 25 years they will, to a lesser extent, still be in practice. Recent experience has shown their adaptability to other activities in the area of health. The government task therefore is to train and supervise them and gradually redirect them to other tasks.



Implementation of Family Planning Program in Bali

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FAMILY planning activities began in Indonesia in 1957, by the establishment of the Indonesian Planned Parenthood Association (IPPA) in Jakarta, as a branch of the IPPF.

In Bali, family planning activities were pioneered in 1961 by a group of volunteers from the IPPA branch. At that time family planning was still not officially accepted by the Indonesian government. Progress of this program was therefore slow until 1969, when the National Family Planning Institute was established. The government announced its official support of family planning in August 1967, and established the National Family Planning Institute. It was run by a private organization and supported by the government through use of facilities (e.g. Department of Information and the Department of Health). The government further realized that population policy is very important to support its 5-year development plan started in 1969. To make it more successful, the family planning program was financed and operated by the government.

The government again reorganized the Family Planning Institute by establishing

the National Family Planning Coordinating Board in 1970.

Information Techniques

Drama Gong, Arja, shadow puppet show are among the traditional media we use to introduce family planning messages. These shows are held frequently in the villages, since they are related to the traditional ceremonies in Bali (e.g. temple ceremonies, three months after birth ceremonies, wedding ceremonies). There are 191 male fieldworkers and 34 females who visit the people in their home and talk to both husbands and wives. There is one fieldworker for every 10,000 people, one group leader in each subdistrict, and one supervisor in each regency.

Family Planning Clinics

The family planning clinics didn't start their activities until 1967. We had 150 clinics (all are complete clinics meaning they have facilities for IUD insertions), 45 doctors, 150 midwives, 150 midwives assistants, 150 clerks, and 225 fieldworkers. In 1971 we introduced a policy allowing midwives to insert IUDs. We

introduced this policy because of a lack of doctors. We also have eight mobile clinics, one in each regency. They go every week to the very remote villages.

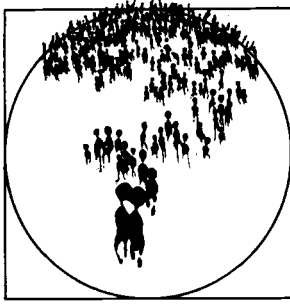
Targets and Achievements

The objective of the family planning program in Bali is part of the national target to recruit 6 million new acceptors in 5 years (to end of 1976). To the present time (mid 1974) we have a total of 127,857 new acceptors in Bali, which is 32.5% of the population of fertile women.

TBAs in Bali

Most of the traditional birth attendants in Bali are men. There are 184 male and 101 female registered TBAs. Most of them are farmers. Because the women are used to male TBAs, male doctors are readily accepted, and the women allow them to insert IUDs.

The TBAs are cooperative and support family planning. No training program has been developed yet for the TBAs, with the cooperation of the group leaders, to motivate them toward family planning practices.



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 Khlung, 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 pre-test-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

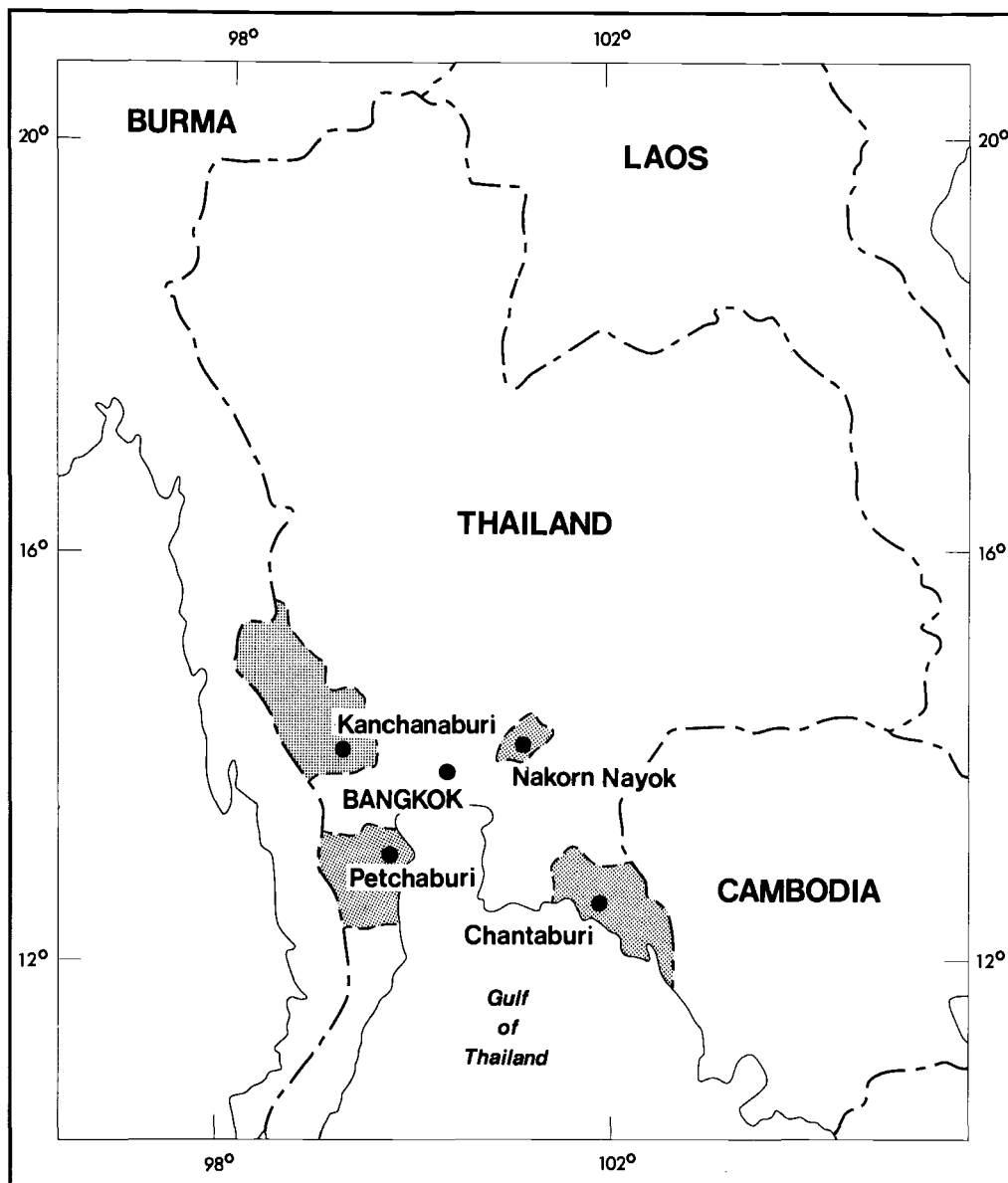


Figure 1. Thailand, showing four areas of TBA study.

operation will be evaluated by interviewing all subjects.

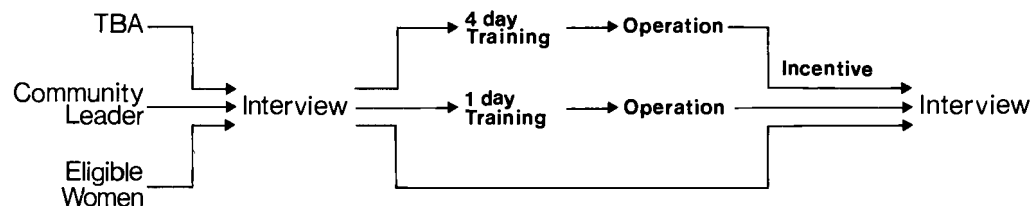
Program Operation

The implementation and operation of this program required three phases:

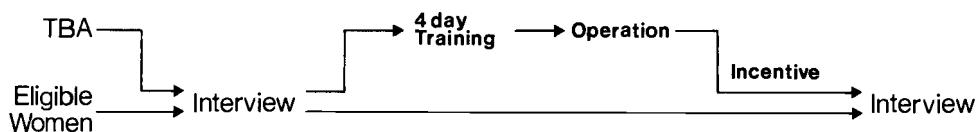
Phase I

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.

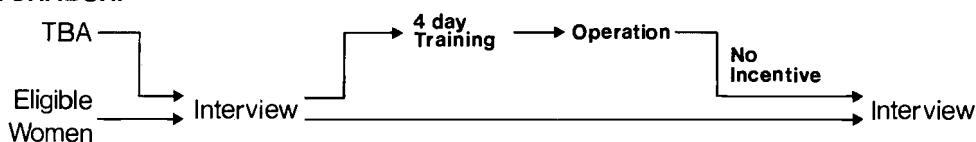
NAKORN NAYOK



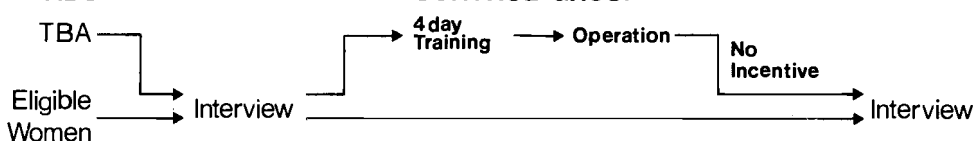
KANCHANABURI



PETCHABURI



CHANTABURI



CONTROL GROUP

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.

Area	No. of TBAs	No. eligible women	No. community leaders
Nakorn-Nayok	32	350	25
Kanchanaburi	30	300	—
Petchaburi	38	308	—
Chantaburi	36	305	—

are illiterate; most are engaged in farming; and about 70% of them had a low income (200 bahts/month and 30% about 400 bahts/month); they have high social prestige; they are local residents; delivering babies is not their major occupation; mean experience of 19.2 years; delivery charge was 25 bahts (\$1.25); 90% had favourable attitude toward family planning; 90% knew how to prevent pregnancy (oral pill, IUD, vasectomy, and tubal ligation were the popular methods, and the average number of birth control methods known was 5.3); 93% were willing to promote birth control among the villagers, and 75% used to advise them even before the interview; and the ideal number of children of a couple in the village should be 4.16, according to the TBAs.

TABLE 2. Approaches given to four areas.

	Training	Incentive	Working with community leader
Nakorn-Nayok	Yes	Yes	Yes
Kanchanaburi	Yes	Yes	No
Petchaburi	Yes	No	No
Chantaburi	No	No	No

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).

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

	Nakorn-Nayok	Kanchanaburi	Petchaburi	Chantaburi
Aug.	1.5	—	1.0	1.0
Sept.	2.3	1.0	1.5	—
Oct.	2.0	1.0	2.0	1.6
Nov.	9.0	1.6	2.0	1.0
Dec.	4.0	1.0	4.0	1.8
Jan.	2.2	1.0	2.1	1.0
Feb.	1.9	0.7	2.6	1.8
Mar.	2.5	1.0	0.8	2.0
Apr.	1.9	2.0	3.0	1.0
May	2.4	0.8	3.0	—
June	—	—	—	—
July	—	—	—	—

Role of Community Leaders

It is generally accepted that in the community organization process, the leaders have considerable influence on the rural people. We strongly agree that the community leaders in the areas where TBAs lived should have some role in the promotion of family planning activities. The community leaders have an important role in referring women to the TBA to be remotivated. At the time of the monthly meeting the community leaders have to advise about the concept of population growth in the villages or nation, the need to plan the size of families, and the socio-economic burden created by too-large families on the village and the nation.

Another role of the local community leader is to endorse the coupon of the very poor

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 Papasathorn, Dean of the Faculty of Public Health; Professor Chindabha Sayanhavikasit, 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

- MINISTRY OF PUBLIC HEALTH. 1972. Health Service Statistics. Bangkok, Thailand.

PENG, J. Y. ET AL. 1972. Village midwives in Malaysia. Studies in Family Planning.

SASICHAN VIMUKTANOND ET AL. 1967. The study of traditional birth attendants in Potharan. Mimeograph. Ministry of Public Health, Bangkok, Thailand.

SRISOMANG KEOVICHIT ET AL. 1974. The preliminary on the study of mohtamyae & family planning. June. Dept. of Maternal and Child Health, Mahidol University, Bangkok.

Appendix 1

Training Program for TBAs

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.

Discussion Summary — Session II

Rapporteur: Ms Aurora Silayan Go

- 1 Attempts at utilizing traditional birth attendants (TBAs) for family planning (FP) activities in the four countries represented show varying degrees of magnitude in the extent of actual implementation, and with regard to the actual initiators behind each program. In all cases, except the Philippines, the government has played an active role.
- 2 Malaysia has one of the boldest attempts in the sense that, short of an explicit policy, recognition of usefulness of the TBA in FP goes beyond the motivational functions of referral of acceptors to clinics. The added task of a resupplier of contraceptives is also being tested.
- 3 Like Malaysia, the Thailand and Philippines activities are selected pre-program experiments with built-in evaluations to test mainly the feasibility of training TBAs, and finding out their impact on the FP objective of convincing potential acceptors to adopt some method of contraception.
- 4 The Philippines has had a national training program for TBAs since 1954 intended mainly to upgrade delivery practices, and to teach them to identify cases that need to be referred to physicians and nurses. This WHO/UNICEF/Government of the Philippines project involves three phases: (1) inventory of all TBAs in the country and gathering of baseline data on the profile; (2) evaluation of the training program; and (3) continued implementation of training with improvements and the addition of FP. Thus, this national effort to date does not represent an attempt to utilize TBAs for FP.
- 5 What the Philippine experience offers is selected studies most of which were initiated by the private sector. An example is the project of the Institute of Maternal and Child Health (IMCH). This series of studies since 1971 is similar to the type of research being conducted in Thailand. The IMCH has provided the National FP program with confidence that TBAs should in future be organized and trained as FP extension workers. To what extent they can be utilized requires further study.

- 6 Thailand is conducting scientifically designed operational research whereby the effect on performance of the TBAS is being tested with regard to provision of training, use of incentives, and strategy of working with community/village leaders. Some interim conclusions from the Thailand study are: old age can be a problem in effectiveness and continuity of the TBAS working in FP; the training program should not be too long (about 5 days); refresher courses are needed (in their experience, about 4–5 months after initial training); and the relationship of regular health workers and TBAS is a crucial consideration in the successful operation of TBAS as coworkers in FP.
- 7 Indonesia's presentation centered on the program in the island of Bali where there is no organized attempt as yet to utilize TBAS for FP. However, Indonesia does have experience to share, since in other parts of the country, they do have training program for TBAS in both MCH and FP. An interesting point about Bali is that most of the TBAS are men. This selection has enabled them to approach wives. In addition, women do not share the problem of having male doctors like other areas do.
- 8 A Malaysian participant felt that TBAS should primarily be FP workers and that a decision must be made on what is expected of TBAS; he also felt that the dual role of MCH and FP would minimize the expected impact of TBAS. This point was debated and the consensus was that a multipurpose function should be adopted, for the simple reason that MCH is the natural entry point for FP.
- 9 An important point was made concerning small-scale pilot testing in a country: government policy must be clarified in support of TBAS otherwise the effort to prove their worth to a FP program may not have the needed support for national implementation.

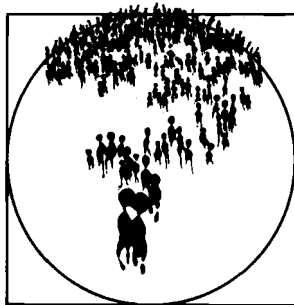
Session III Papers

Problems Found and Lessons Learned from the Operation

Chairman: Dr Soebagio Poerwodihardjo



TBAs receiving instruction on the proper methods of attending childbirth



Problems and Findings from the TBA Program in the Philippines

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Manila, Philippines*

ONE of the vexing problems in the delivery of measures and efforts for development and progress in many developing countries is how to make these reach remote localities. With over 7000 islands the Philippines presents great problems in the delivery of health care, and now also in the implementation of the national population program of the country.

In a desire to help overcome the manpower problem in the delivery of family planning in remote areas, the staff of the Institute of Maternal and Child Health, Philippines (IMCH), considered the potential of "hilots" or traditional birth attendants (TBAs) as family planning workers, not only because of their favourable attributes, but also because of their tremendous numbers in the Philippines (over 31,000). Since 1956 about 9000 TBAs have been trained by the Department of Health, with UNICEF assistance, to improve their services to expectant mothers and to the newborn babies.

The first study started in May 1971 in the island province of Marinduque (Site I), and in Camarines Norte (Site II) in November 1971. The following year (May 1972) a third project site was started in Mindoro Oriental (Site III).

The same general objectives were applied to the three sites but specific objectives varied with different inputs, in order to allow comparisons and specific recommendations.

In the first site, Marinduque, an anthropologic study was carried out by the Department of Anthropology, University of the Philippines, when the work was in progress, while the Institute of Philippine Culture, Ateneo University, did a pre- and post-project anthropologic study in Mindoro Oriental. Both studies give informative and interesting observations and data which are helpful in understanding TBAs and their performance and, to some extent, in evaluating this project.

The TBA

The TBA has always played a role in obstetrical practice and in neonatal care in many areas of the Philippines, particularly so where medical and paramedical workers are not available. They have continued to carry on their activities through the years and, in fact, their services are increasingly sought as medical manpower continues to decrease in remote areas. Approximately 74% of deliveries take place in the home

and 24% in hospitals or clinics, and about one half of births occur without benefit of medical or paramedical attendance. Thus in 1971 only 22.7% of births were attended by physicians, 17% by nurses, and 29.4% by midwives.

The warm association of TBAS with women before and during labour, and even for weeks after, places them in a preferred position over physicians and paramedical personnel.

Since 1956 the Department of Health with UNICEF assistance has undertaken a training program for approximately 9000 selected TBAS to enable them to handle the difficult situation found in rural areas where physicians and paramedical personnel are not available. The TBAS are expected to fill the gap while the government is training unlicensed midwives. This training has lagged lately due to other pressing problems in the country.

The present project looks into the delivery of maternal and child health care by TBAS, how to provide them with updated and accepted basic knowledge and skills necessary for the care of the woman during pregnancy and delivery, together with recent trends in the care of the newborn.

The addition of family planning is a new feature in the TBA curriculum, as a trend in MCH services. The Director of the WHO Regional Office in Manila recently emphasized the importance of the TBA in the national efforts on family planning.

Goals and Objectives

The general objective was to determine how best to utilize the TBA not only in her traditional role as birth attendant but also as a family planning motivator in remote rural areas.

Specific objectives included: collection of information on traditional and present services for maternal and child health in the community, and the factors affecting the utilization of such services; collection of demographic and health statistics of the communities covered by the study, compila-

tion of general information on practicing TBAS; reduction of maternal and neonatal mortality and morbidity by updating the practices of the TBAS; involvement of TBAS as family planning motivators; determination of what factors may increase the effectiveness of TBAS as family planning workers; and exploring other possible roles in family planning which may be assigned to TBAS.

Methods

The project staff at headquarters included a project director, two assistants, a statistician, an accountant, and a clerk. All worked part-time, and the last three only were paid. The field staff included a full-time medical supervisor, a part-time provincial public health nurse, and a driver. The staff of each puericulture and family planning centre included a part-time physician, a full-time nurse and midwife, and a part-time lay motivator.

A TBA leader or president was elected who helped on a voluntary basis in the activities of TBAS in the area.

Procedure

The headquarters staff first made a courtesy call to government and health authorities and to some community leaders. This was followed by a survey of the project site, and local staff were briefed on the project, its objectives and implementation, and their respective duties and responsibilities.

Selection of TBAS was done by the local public health nurse and the family planning clinic staff. Preference was given to those in active practice and those who had taken training offered by the Department of Health. It was decided, however, to take as many TBAS as possible.

Training

A total of 482 TBAS were trained. The Puericulture and Family Planning Centre was the training site under two staff members from headquarters and assisted by the local clinic staff. The training course lasted 5-8 days; and the curriculum was the same for all three provinces. Topics included birth

registration, anatomy and reproduction, nutrition and care during pregnancy, abnormalities and indications for referral during pregnancy, stages of labour, preparation for delivery, conduct of labour, care of the newborn, postnatal care of the mother, family planning, etc.

A pre- and post-training questionnaire was answered by each TBA.

The stipend was P7 daily to cover transportation (P2) and meals (P5). A certificate of attendance was distributed at the end of the course together with a plastic kit and some basic equipment for birth attendance and reading materials for FP motivation.

Training was conducted in the local dialect and teaching methods consisted of demonstration with flip charts and mannequins, workshops, role playing, slides and movies, and field trips.

TBA Roles After the Training

In Marinduque (Site I) 25 trained TBAs were selected to receive a monthly stipend of P50 each for their motivational activities, and they were expected to recruit 10 acceptors monthly and attend five "follow-ups." After 3 months this procedure was changed to 50 TBA motivators at P25 and a target of five new acceptors and five follow-ups. If in three consecutive months an individual failed to reach the expected quota, she was replaced by another trained TBA.

In the two other project sites all trained TBAs were involved as FP motivators and no stipend was given.

A coupon system was designed to facilitate the referral of a client who had been motivated by the TBA to a FP clinic. The coupon is filled in by the TBA and this is taken to a clinic by the acceptor. There she is examined and the different methods are explained to her. If there are no contraindications, the method she chooses together with the date of acceptance are noted on the coupon, and the TBA motivator through this coupon would be given credit for this acceptor. The supervisor collects all the coupons for evaluation during the monthly meetings.

Supervision

Project Sites I and III had a full-time medical supervisor who conducted monthly meetings with the TBAs. This gave the TBAs opportunities to present and solve their problems, to get new information, to receive motivation or other materials to help in their work as birth attendants and FP motivators, to report deliveries they assisted, and to submit registration forms. From time to time the field supervisor visited the TBAs in their localities.

In Project Site II there was no field supervisor; nevertheless, the TBAs assembled monthly and met with the clinic staff of the puericulture centres.

There was also an annual meeting of TBAs. This served as an overall evaluation of the TBA activities and also as a social affair.

Anthropologic Studies

In the first project proposal an anthropologic study was not planned as the key staff were familiar with the area and its people. However, initial observations on the TBA performance showed that success or failure could not be measured simply by the number of acceptors or drop-outs. We therefore undertook a study to further explain the results of the first 6 months, and also to give insights that would lead to a more efficient involvement of the TBAs as family planning motivators. The Department of Anthropology, University of the Philippines, was requested to undertake this study in Marinduque.

The study was beset with problems, principally severe typhoons, a prolonged rainy season, transportation difficulties, and political adjustments.

In the third TBA project (1972) in Mindoro Oriental pre- and a post-project anthropologic studies were included. This study was under the Institute of Philippine Culture, Ateneo University, and its general objective was to assess the impact of the IMCH training program on the TBAs MCH practices and FP motivational activities, 1 year after the training.

The study focussed on the TBAs activities in family planning, this being the innovative aspect introduced into their work. The feasibility of utilizing the TBA in barrios seldom reached by other motivators is equally important, since the IMCH training may define guidelines for future TBA training programs.

Refresher Course

A 2-day refresher course was held in May 1973 in the three project sites for all participants in the TBA Training Program. The objective was to discuss the effectiveness of the training and to receive suggestions for future activities. The TBAs filled out a questionnaire to determine the extent of their involvement in the MCH/FP program during the previous 2 years, and the problems they met. A total of 423 attended of the original 484 who trained.

Observations and Discussion

A total of 482 TBAs were included in this study; all had training of 1 or 2 days in each project site. A refresher course was given about 2 years after the first training. The curriculum, methods, and training stipends were the same.

After their training, 50 of 142 trained TBAs were involved as motivators in Project Site I while every TBA who was trained was included in Site II (50) and Site III (290).

Inputs varied in the three sites. Thus in Marinduque besides the training and refresher course, a stipend was given and there was a full-time supervisor; also, an anthropologic study was undertaken 6 months after implementation of the project. In Camarines Norte the only input was a training and refresher course. In Mindoro Oriental no stipend was given; the other inputs were similar to those of Marinduque.

TBAs in Marinduque who received stipends were divided as follows: Group I: 25 TBAs received P50 monthly and were expected to bring in at least 10 new acceptors monthly. After 6 months the number of TBAs was reduced, thus: Group II: 50 TBAs received P25 monthly with a target of five acceptors/TBA per month.

TBAs as FP Motivators

Can TBAs be involved in motivation activities in family planning, even though this might conflict with their traditional work as birth attendants? Our studies indicate a definite yes.

In Marinduque, of the 142 TBAs trained, 70% were responsible for at least one acceptor. As a group, they motivated 1021 acceptors or 3.6% of the eligible women in the province during a 15-month period. About 96% of their acceptors selected effective contraceptives such as pills and the IUD.

Effects of Supervision

The number of acceptors obtained by TBA motivators in the supervised project area was twice that of TBAs in the nonsupervised site during the same 15-month period.

Obviously supervision favourably affects the number of new acceptors motivated by the TBAs. It also increases the length of time they will actively work as FP motivators.

Effects of a Stipend

Data collected from two project sites, one with and the other without a stipend for the TBA motivator, show that there were three times as many acceptors where a stipend was given.

Problems

Because of their limited interests, their low educational level, their age, and often short concentration span, exceptional effort is needed to train the TBAs.

Transportation Difficulties of transportation and means of communication are determining factors in motivation activities as well as in getting acceptors to the clinics. This problem is most discouraging in remote areas.

Sustaining interest in FP activities Enthusiasm and interest in a relatively new field is high at first but soon wanes. Maintaining this enthusiasm is a difficult problem.

Side effects and complications Unfavourable effects or occasional side reactions and complications arising from the use of contraceptive methods present difficult problems

everywhere, but in small villages where news spreads very fast, these can be disastrous for the program. TBAS often find it difficult to counteract such bad news.

Stipends Studies show a real need for some type of reward for efforts and services of the TBAS as well as to cover their expenses. Determining the amount and method of payment presents problems.

Follow-up of acceptors Although the importance of follow-up is emphasized in the training, during monthly meetings, and in the refresher course, there is a tendency to slow down or stop follow-ups of acceptors.

Cooperation of other family planning workers Some TBAS feel that the clinic staff do not seem interested in their efforts and, in fact, they complain that some of their acceptors are "lost" to other motivators. This happens particularly in clinic-based FP activities where the staff have quotas to meet.

Lessons Learned

TBAS in the Philippines can be effective family planning motivators, given adequate motivation and training, encouraging incentives, and backed by some kind of supervision which is competent and sensitive to the circumstances in which they live and work.

All TBAS should be trained, not only in the conduct of normal pregnancy and the recognition of abnormal cases, but also on family planning: its importance, the different acceptable methods, techniques of motivation, and integration of FP into their daily activities.

Training should be practical, easily understood, lively and simple, with audio-visual aids and materials that will sustain their interest. There should be field work and opportunities to practice motivation, and then to discuss their observations and difficulties in performing their roles.

Training and supervision should be reinforced by periodic meetings and possibly refresher courses.

Selected TBAS may be appointed as family planning motivators, with a monthly stipend

plus an additional fee over an expected reasonable performance in accordance with circumstances in the locality. Possibly also a bonus may be offered in recognition of outstanding work.

Initiative, resourcefulness, and innovative approaches or procedures may be encouraged with suitable incentives.

TBAS may be involved in other roles in the community to keep them active and enthusiastic and to make them feel useful and wanted.

Most of the TBAS beyond the age of 55 retained their old practices in attending deliveries. These so-called "hard-headed" TBAS have not integrated family planning motivation to any significant extent in their birth-attending activities. They would rather attend deliveries only and leave motivation activities to the younger TBAS. However, it is best to include even these older TBAS in the training and monthly meetings as they could harm the program if ignored.

A weak point of TBA motivations is that they tend to limit this to the parturient mothers they attend and to their own relatives. Only a small percentage of the TBAS motivate outside of their immediate family circle.

Some type of supervision that would be practical and suitable for a particular locality is advisable and this will eventually pay off in terms of performance and continuity. Supervision should be done by one who is from the local area, with authority, but at the same time a pleasant, understanding, patient, and persistent attitude.

It appears that TBAS constitute an important modification in the classical diffusion model which assumes that field workers should have a high level of technical competence. In this study it is realized that less formally competent change agents like TBAS possess another kind of credibility among those they serve, based on a high degree of prestige and respect they possess in their own community. Behaviour of people in certain situations, in-

cluding TBAs as motivators, can be stepped up to desired levels given realistic incentives and favourable means of implementation.

Acknowledgments

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Selected Bibliography

BAILLEN, J. B. 1974. Traditional midwives and modern family planning in Marinduque. University of the Philippines, Department of Anthropology.

CROLEY, H. T. ET AL. 1966. Characteristics and utilization of midwives in a selected area of East Pakistan, *Demography* 3:578-580.

DIZON, J. A., AND V. A. MIRALAO. 1973. The hilot in Oriental Mindoro. Ateneo de Manila University Institute of Philippine Culture.

EAST-WEST COMMUNICATION INSTITUTE. 1974. IEC Newsletter. No. 16, Jan. 1974. "Midwives carry information supplies to rural Malaysia."

GORDON, J. E. ET AL. 1965. Midwifery practices in rural Punjab, India. *Amer. J. Obstet. Gynec.* 93:734.

HART, D. 1965. From pregnancy through birth in a Bisayan Filipino village, in *Southeast Asian birth customs: three studies in human reproduction*. New Haven, Conn.: Human Relations Area Files.

JAFAREY, A. S. 1968. Use of medical-paramedical personnel and traditional midwives in the Pakistan family planning program. *Demography* 5:666-678.

KING, M. (ed.) 1966. *Medical care in developing countries*. Nairobi, Oxford University Press.

LOPEZ, E. 1974. The hilot in family planning: An evaluation of the IMCH Program in Oriental Mindoro. Ateneo de Manila University Institute of Philippine Culture.

PENG, J. Y. ET AL. 1972. Village midwives in Malaysia. *Studies in Family Planning* 3(2): 25-28.

PHILIPPINE HEALTH STATISTICS. 1969. Department of Health, Republic of the Philippines.

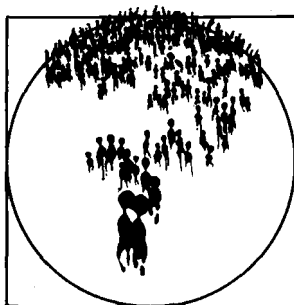
ROGERS, E. M. 1973. *Communication strategies for family planning*. Free Press, New York.

TAN, A., AND A. TAN. 1920. A study of "hilots" in the town of Bay, Laguna. *J. Phil. Med. Assn.* 46:391.

TAYLOR, H., AND B. BERELSON. 1971. Comprehensive family planning based on maternal and child health services: a feasibility study for a world program. *Studies in Family Planning* II (February 1971), p. 21-54.

WILLIAMS, C. C., AND D. B. JELLIFFE. 1972. *Mother and child health delivery services*. Oxford University Press.

WORLD HEALTH ORGANIZATION. 1966. The traditional birth attendant. *World Health Organization Technical Report Series* 331, 16 p.



Problems and Findings from the TBA Program in Thailand

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EXPERIENCE from field training of students of the Faculty of Public Health, Mahidol University, had shown that one of the major health problems in the rural villages is maternal and child care. For example, 80% of deliveries in the rural areas were attended by husbands, other women, relatives, neighbours, and traditional birth attendants (TBAs). TBAs attended 60% of all such deliveries.

Thus the TBAs who are involved in such maternal and child health services should not be neglected. They are very influential and command the respect and confidence of the villagers.

Recognizing the significance of the TBAs, the Faculty of Public Health, Mahidol University, in conjunction with the National Family Planning Program, Ministry of Public Health, attempted to recruit them for family planning services (e.g. to motivate village women to accept family planning in particular).

The Faculty therefore requested aid from the International Development Research Centre (IDRC), to support a 2-year training project on the role of the traditional birth attendant in family planning. We are seeking to define the most effective means for the

TBA to perform her duties and to motivate as many family planning acceptors as possible.

Objective

The objective was to identify various problems that acted as deterrents in the acceptance of family planning. This will enable FP services to reach most of the villagers and help correct any misunderstandings and rumours which are serious drawbacks in the program. It should also improve the efficiency of health personnel, and help them and other officials to recognize the significance of the TBAs who are in an excellent position to render assistance in FP services.

Characteristics of TBAs

The TBAs over 50 do not want to work because they tire easily and experience difficulty in walking. The number of inactive TBAs between 50 and 70 years is 106 (from a total of 136, or 77%). In this group of TBAs only 32 had ever motivated women to adopt family planning.

This under-50 group is active. There are 30 TBAs, and 14 of them have attempted to motivate women to adopt FP. One outstanding TBA from this group recruited 48 acceptors, a record in the four provinces.

Except for those TBAs (16%) living with sons or daughters, and taking care of the grandchildren, 83% had other jobs and sources of income since income from their TBA work was not sufficient.

Incentive Payment

In Nakorn Nayok and Kanchanaburi provinces, in order to receive the monthly incentive money, the TBA had to travel from the village to the health centre. The amount of money received was usually very low in relation to the distance travelled and the bus fare (the lowest sum of money received was 2 bahts and the highest 25 bahts which occurred only once).

In the province which paid no incentives and the control area, the TBAs do not have to go to the health centre as often. The acceptors usually asked her to accompany them to the health centre. The women occasionally paid the bus-fare for the TBA. The TBAs therefore stop distributing coupons because they might lose money on bus expenses.

The low educational level of TBAs reflects in their lack of motivation in recruiting FP acceptors. Over 64% never went to school, 14% had up to 3 years schooling, and 21% had more than 4 years.

Characteristics of Acceptors

Many false rumours circulated about the pill: e.g. when used for a long period of time the pill caused cancer; the pill cannot prevent pregnancy (this rumour caused less confidence and reluctance for those who newly started taking the pill); some minor side-effects of the pill such as: headaches turned out to be neurosis; nausea, vomiting caused fatigue which affected work; abnormalities in menstruation; the pill caused gain in weight, diminished sexual ability, caused freckles, darkening of the skin, etc.; and the pill caused difficulty in labour.

These types of rumours affected a number of new acceptors and caused loss of continued users.

The hard-working acceptors, or those who had to travel very far for work, lost contact

with the TBA, however they bought their own pills from the drugstore at the market place.

Some acceptors wanted other services besides pill distribution but the second-class health centre or the midwifery centre could not provide these.

Acceptors' houses were too far or out of the way from the market place or the midwifery centre.

There was also a degree of shyness in receiving the service (especially the IUD), and a concern that other people might know about them receiving the service.

In some areas, the relationship between the local nurse or midwife and the acceptor was better than that between the TBA and the acceptor. This prompted the acceptors to come directly for the service without taking coupons from the TBA.

Although the service is free, the acceptor has to pay travelling expenses and sometimes she is too busy to report to the clinic.

Characteristics of Health Personnel

The service rendered by the midwifery centre was not sufficient in terms of acceptor's needs. For example, some wanted to have the IUD inserted but this service was not available. If the acceptors could not get along well with the pill, they had no alternative method. The other factor was the long distance between the village and the first class health centre or the hospital where the various kinds of contraceptive methods were offered. Many could not afford to come for the services, leading to a decrease in the number of acceptors.

The midwifery centre is a one-person clinic, and her home visits and pill distribution duties frequently took her away from the clinic. Acceptors got discouraged when they arrived at the clinic for resupply of pills and found the clinic closed.

In 1972 the government reorganized departments in the Ministry of Public Health, and some of the administrators in FP programs at the central and provincial level were

transferred to the new Department of Medical and Health Services. A new Project Director and Deputy Project Director were appointed. Because of these changes, supervision of FP workers lagged and morale suffered.

The health workers had a negative attitude toward health services and FP programs. They do not appreciate the importance of helping people, especially the poor and ignorant, and lack mercy and sympathy. The health workers did not devote themselves to the work entrusted to them.

A lack of communication between the officials and health workers causes ineffective co-operation and unfavourable results.

Some midwives, because of personality conflicts with the TBAs were ineffective in motivating and supervising them.

Other Conditions

The lack of success can be further attributed to the following: poor transportation and long distance to health centres; seasonal variations such as farming periods or temporary migration for jobs; the community leader disagreed with the family planning programs and would not cooperate with the TBA; some community leaders suggested that the period for service should include the night as well, because some acceptors had to work until late evening; the older relatives of the acceptors had a negative attitude toward FP; and a brand change of pill during 1973-74 caused a great decrease in acceptors (20% of all acceptors). The problem started in 1972 when USAID changed the pill from Oval (Norgestrel 0.5 mg and Ethinyl estradiol 50 mg) to Norlestrin (Norethindrone acetate 1.0 mg and Ethinyl estradiol 50 mg). This new brand of pill was claimed by many users to cause headache, nausea, vomiting, and abnormal bleeding. Although the USAID tried to solve the problems by sending another brand, Demulen (Ethinodiol, Diacetate 1 mg and Ethinyl Estradiol 50 mg), the Family Planning Unit, Ministry of Public Health purchased Oval for distribution again. But the users still felt uncertain about using the pill

once again due to its effectiveness in prevention of pregnancy.

Lessons Learned About the Training Program for TBAs

We found that the training should be more comprehensive and more frequent than previously. The limiting factor is the low educational level of the TBAs which requires very careful study design and procedures consistent with their ability to understand. The well-trained TBA can also gain approval from well-educated eligible women and to clarify all rumours about contraceptive methods.

To increase the effectiveness of training, the TBAs should be grouped according to their abilities.

The evaluation of the training program can be performed to find out the behavioural change of TBAs, the behavioural changes of the women residing in the same area as the TBA, and the number of new acceptors recruited. Although it is too early to evaluate the program, we can conclude, however, that many TBAs can be trained as motivators in the FP program. The factors influencing the

TABLE 1. The number of active TBAs and the number of acceptors (in three implementation provinces).

	No. of active TBAs	No. of acceptors recruited by TBAs
<i>1973</i>		
Aug.	6	8
Sept.	9	18
Oct.	10	17
Nov.	13	45
Dec.	13	46
<i>1974</i>		
Jan.	13	27
Feb.	13	23
Mar.	17	28
Apr.	16	35
May	16	33
June	-	-
July	-	-

behavioural changes of the TBAs include age, understanding, interest, willingness to work,

family responsibilities, and their relationship with the local government health personnel. In this program the number of active TBAs varied from month to month (Table 1). The number of acceptors recruited also varied. However, the ratio of TBA to acceptor might indicate a relationship between TBA activity and the November refresher course. In that month, the number of active TBAs did not increase significantly, but their efficiency did increase.

Incentives for TBAs

If TBAs motivate a woman to adopt family planning service, they receive 10 bahts (50¢) per new acceptor. The procedure normally requires three visits to the home of the eligible woman.

The TBAs are not always happy with the incentive paid, since travelling expenses are often higher than the amount of the incentive. This has to be taken into consideration to further improve the incentive scheme.

In Kanchanaburi we trained TBAs and gave incentives, but in Petchaburi we trained TBAs but did not offer an incentive. Despite this fact, the number of acceptors from Petchaburi was higher than for Kanchanaburi. The incentive payment may not be necessary in some areas, or the method of giving incentive may not be satisfactory.

The Coupon System

In order to help identify the new acceptors of family planning who were motivated by TBAs, a special coupon was developed. The coupons given by the TBA to the eligible women are collected at the designated health

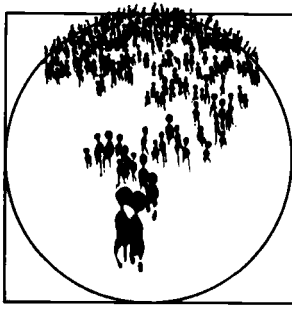
centre by the nurse. Different groups of TBAs are given different colours of coupons.

From experience, it seems that the coupon system only helps to identify the TBAs. The acceptors didn't see any value in having a coupon to get the pill from the midwife.

Some midwives had personal conflicts with TBAs which caused difficulties in motivating or supervising. Others had rather unfavourable attitudes toward public health workers and family planning, with a noted lack of sympathy toward the poor and uneducated. This caused a rift in the good relations with the villagers. We must develop an understanding and friendly atmosphere which will be good for the community and the family planning program.

We propose that the distribution of oral pill should be done at night clinics for those who have to work late. This could begin at a local ceremony such as funeral ceremony or the ceremony for entering the priesthood. The community leader also supported this idea. The pill would be distributed first by the health worker and resupplies made by the TBAs.

Another suggestion was that the clinic should be opened for longer periods, especially since most of the health workers live nearby. The dinner period (1700–1900 h) for the health worker might be the most suitable time for many acceptors who finish their work in the field and come for their pill. If the health worker can sacrifice some leisure time for pill distribution, it would be very beneficial to the family planning program.



Problems and Findings from the TBA Program in Indonesia

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TRADITIONAL birth attendants (TBAs) in East Java have no formal training. They learn the trade by assisting older TBAs. They are mostly elderly women, 50–60 years of age, and usually widowed or divorced. Most are illiterate, and their role of a TBA is only part-time. Many of them are housewives or a farmer's wife, while some have a business of their own. From their activities as a TBA, they earn about Rp. 2000 to 3000 per month (approximately US\$5–7) in cash or in kind. The TBA is called by the delivering mother because she is readily available, cheap, and familiar. Qualified midwives are scarce, and more expensive.

Training TBAs in MCH

The government MCH services are still not adequate to serve the entire population of Indonesia.

Therefore, the MCH workers are attempting to make temporary use of the services of the TBAs by giving them training for attendance at normal child births.

In 5 years (1969–74) the Directorate of the East Java Provincial Health Service (the provincial MCH Services) trained 8410 TBAs of a total of 18,480 in the country (Table 1). The MCH-trained TBAs attend about 43% of

all deliveries in the province of East Java (Table 2).

TABLE 1. TBAs trained for MCH services, 1969–74.

	1969– 70	1970– 71	1971– 72	1972– 73	1973– 74
Number of TBAs in the regions	12,768	15,370	18,100	17,858	18,480
Number of trained TBAs	7,428	7,252	7,271	7,689	8,410
Percent trained	58.18	47.18	40.11	43.11	45.48

TABLE 2. Deliveries by TBAs.

	1969– 70	1970– 71	1971– 72	1972– 73	1973– 74
Number of deliveries	300,676	348,835	389,703	370,639	338,394
Deliveries attended by TBAs	144,076	153,415	162,671	144,960	139,881
Percent attended by TBAs	47.9	43.3	41.7	39.08	41.3

TBAs as FP Motivators

The TBAs could play an important role in the FP movement as a motivator and as a referrer. MCH-trained TBAs are already administratively attached to MCH/FP clinics. They report monthly to the supervisor. The course is given by the MCH/midwife during 5 consecutive days (or on 5 market days). The principles taught are kept as simple as possible: a) pregnancy and delivery, if they happen too often with short intervals between babies, will harm the health of both mother and child; b) raising healthy children requires a lot of money and effort; and c) since their holdings in ricefields are mostly very small, they can only provide food for a certain number of children, so they should join the FP movement and go to the FP clinic.

The Directorate of Health Services trained 4505 TBAs as FP motivators up to March 1973, out of a total of 7689 TBAs. The training cost the government Rp. 6,000,000, the average cost per TBA being Rp. 1,332 (approximately US\$3).

Achievements of the TBAs in FP

A study was conducted in the district of Mojokari covering 127 TBAs by Pardoko and Soemodinoto (1972). They reported the following conclusions: The average income from attending deliveries was around US\$2.53/month and the TBAs were attending an average of four deliveries/month. Almost none of them had any experience in postponing their own pregnancies, and none were practicing family planning at the time of the study. Only one third were concerned that their source of income would be affected by the family planning program launched by the government. One third had the opinion that women in the village would be embarrassed if other people knew they were practicing family planning.

The records at the clinic in the study area showed that the number of new family planning acceptors referred by these TBAs was increasing, with more than 200% in the first

2 months after the initiation of the study, but declined very rapidly after that. This decline paralleled a decline in the number of participating TBAs during the study period, and also to a lack of success the TBAs had in persuading women to visit the clinic.

Due to old age, they were physically unable to make regular visits to the homes of the women in the village, since between 12 and 30 visits were required to recruit one acceptor. By interviewing the women who had been contacted by the TBAs, Pardoko and Soemodinoto found that 83% of them understood what the TBA had told them about family planning.

The experience of family planning clinics in East Java outside the study district is the same. When TBAs receive training and start to work, their enthusiasm is initially high, but soon starts to wane.

Developments

The important role the TBA plays in FP motivation can be considerably enhanced through the involvement of other health staff and FP fieldworkers. Governors are now responsible for the success of FP efforts in their areas. The family planning coordination body at the provincial level becomes an assisting agency to the governor, and every agency at the provincial, regency, district, and village level is mobilized to do information and motivation work to help persuade and educate the people toward adopting family planning.

The medical/contraceptive services should not only be available in the FP clinics, but in the villages as well.

In addition to promotion of FP through official government agencies, we have sought and obtained the cooperation of Moslem religious leaders who are requested to participate actively in dissemination of information and motivation. As the civil and village administrators and religious leaders have a great influence on the population, the largest number of new participants is produced by this group of organizations.



Health workers visiting household in village in Perlis, Malaysia

Staff members of the Health Services and FP fieldworkers are members of information/motivation teams, while the FP clinic will provide medical services in the clinic itself or in the village.

With this mass approach to FP the role of the individual TBA becomes relatively small.

In East Java the TBA produced about 3% of the 642,000 new participants in 1973-74.

Conclusions

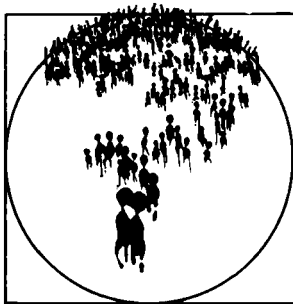
The importance of TBAs in propagating the family planning idea will depend on the approach to the problem prevailing in the region. If the "individual approach" is used, the TBA can significantly contribute to the success of the program, especially where there

is a lack of trained fieldworkers. The training of TBAs is not expensive, but should be followed by refresher courses and revision of the monetary incentives.

In the "mass approach" used in East Java, the role of the TBA becomes small. They cannot compete with village administrators and religious leaders in their influence on people. Their overall effectiveness is on the decline and will eventually be replaced by educated and trained health workers. In the meantime, however, we will continue to utilize them to the fullest extent.

References

- PARDOKO, R. H., AND SOEKANTO SOEMODINOTO. 1972. Dukun as referrer of family planning acceptors. A study in East Java.



Problems and Findings from the TBA Program in Malaysia

HAJJAH ZAHARAH BTE. ABDULLAH

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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.

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.

Conclusions

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.

The Kota Baru Experience

WAN KHADIJAH BINTI WAN HUSSAIN

*Staff Nurse in Charge
National Family Planning Board
Kota Baru*

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, Jerleh 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).

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 Perlis Experience

LIM KIM GOEY

Staff Nurse

Beseri Health Centre, Perlis

IN Perlis about 40% of deliveries are still conducted by TBAS. Although these women have no formal training, they are active and influential in the community and the women will listen to them rather than the health staff. By having the TBAS participate in the family planning program we can lessen the burden on the rural health staff that will arise from the integration of family planning into rural health services.

The utilization of TBAS in family planning was introduced in Perlis in 1972, and 12 TBAS were selected for training. They ranged in age from 40 to 60 years. The course included a 1-day training period for the trainers followed by 3 days training of TBAS. The training was in the form of simple, concise lectures followed by question and answer sessions and role-playing. The training concentrated on practical exercises of handling the coupons and motivating acceptors. The TBAS were given a monthly allowance of M\$30.00 at a monthly meeting when they hand in the resupply coupons to the supervisor. The TBAS were assigned supervisors during the training. The TBAS are distributed throughout the province as follows: Kangar (Capital of Perlis) 3, Simpang Empat 2, Kuala Perlis 3, Kampong Gial 1, and Beseri 3.

During the first month, the TBAS brought in 36 acceptors. Some of them accompanied the women to the clinic for the initial acceptance, allowing the staff nurse to screen the women accepting a contraceptive method and to fill out a complete acceptance form. The women are given the first month supply of pills together with green coupons. To get her resupply of contraceptives from the TBAS the woman must present a green coupon each month. After 6 months on the pill the woman must report to the health centre for a check-up and a new supply of green coupons.

A refresher course for the TBAS was held in January 1973. Bonuses were given to them according to their workload. The total number of acceptors in 1972 was 228. Another evaluation was held in April 1974. The TBAS were again given bonuses based on performance. The total number of acceptors in 1973 was 113. By 1973, three TBAS had dropped out of the project for various reasons (home too far and too remote, difficult to get supplies especially during rainy season, etc.).

The highest acceptor rate and continuation rate comes from one of the TBAS in Beseri. She is very soft-spoken and conscientious. She does not attend many deliveries but helps the government midwife in massaging the mother after the delivery. Even though she is called to conduct deliveries she will call for the government midwife. She leans more toward family planning work. When she motivates the mother on family planning, she first approaches the elders and explains to them the importance of family planning. After getting the elders on her side it is quite easy for her to convince the young mother to accept family planning. She will take the women to the clinic if they are frightened to go alone. She knows all her clients very well and will visit them at home if they do not get their resupply of pills. With the help of her daughter, she keeps a record of all the women taking the pill. In this way she knows whether the women have taken their resupply for the month.

Conclusions

Although we face certain problems with the TBAS, such as poor record-keeping and lack of accurate information about their activities, we feel that they are making a worthwhile contribution to the national family planning program and should be encouraged to continue their work.

Discussion Summary — Session III

Rapporteur: Dr Bachtiar Ginting

- 1 The problems found can be classified in relation to:
 - a) *Traditional Birth Attendants (mostly elderly women) having:* little knowledge in modern medicine and family planning; limited skill in delivering babies (acquired traditionally from their elders); attitudes in family planning not yet defined (Indonesia, Thailand and Malaysia); no education, a responsibility to manage the family, and who usually stick to traditional beliefs (Thailand, Malaysia and Indonesia).
 - b) *Health care delivery system/Health manpower:* not always available in rural areas, when the people are already motivated to family planning to get the services (Thailand, Philippines and Indonesia); the health units are usually out of reach of the people who want its services (Thailand and Indonesia); the attitude of the health manpower is still not positive (Thailand) toward family planning; the utilization of health manpower and health units is very low (Indonesia and Philippines); the need for a workable and practical supervision/control system in order to save money and to control the program, and to enable a proper evaluation of each program; and finally, how to integrate the TBA in MCH and FP programs, and establish their relationship to the whole system and to the categorization of health and FP manpower.
 - c) *The Environment/Community/Government:* low educational and social conditions of the rural population need special treatment, and methods of recruiting, keeping and providing services for the acceptors of FP; communication (transportation) in rural areas is one of the main problems of acceptors of FP; level of knowledge of FP concepts is very variable within the community; the policy in implementing FP in some countries is still not well coordinated, except in Indonesia and Malaysia where there are coordinating boards for FP.
- 2 *The lessons learned*
 - a) The roles given to TBAs vary in each country: (i) Malaysia: motivator and distributor of contraceptives; (ii) Indonesia, Thailand, and Philippines: motivator.
The TBAs still continue their traditional role of birth attendant even after receiving training in hygienic ways of delivering babies.

b) Problems arise in the supervision of TBAs who participate in FP programs because of their widespread distribution and lack of supervisory personnel. The supervisory system in health care delivery has not yet been developed effectively.

In Malaysia this has been done through the use of coupons, the monitoring of the number of acceptors recruited by the TBA, periodic meetings, and supervision directed in the field by the FP program official.

c) Because the number of trained TBAs who will participate in FP programs is not very encouraging in the Thailand experience, it was recommended that special care be taken in recruitment of TBAs for training. The Malaysian experience can be considered by other countries.

d) *Bonus/Incentives* Although opinions varied, participants from Malaysia, Philippines, and Thailand showed significant results for increasing the number of acceptors through the payment of bonuses. The money allocated for this purpose is not supplied by the respective governments. If the money is available, it is recommended that the method used in the Malaysian program be tried.

e) If the FP approach is "mass action" the role of TBA as motivators would be very limited.

f) In implementing the FP program we have to integrate all disciplines such as sociologists, physicians, etc.

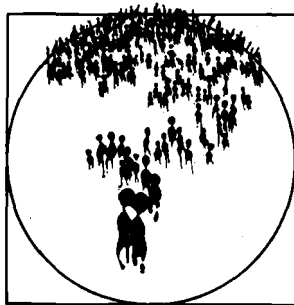
Session IV Papers

Outlook and Research for the Future

Chairman: Dr M. Subbiah



Part of the training of TBAs includes role-playing — here the TBAs practice instruction on the proper use of the oral pill



Outlook and Future Research in the Thailand TBA Program (Part 1)

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DUE to a lack of trained MCH personnel, especially in rural areas, the Thai Ministry of Public Health, with UNICEF assistance, conducted a training program almost 10 years ago, for traditional birth attendants (TBAs) in the field of MCH.

The TBA attends more than 60% of total deliveries of rural women in many communities in Thailand. She therefore plays a definite role in relation to the health of families and she is regarded as an influential member of the community. She has a vast knowledge of traditional lore, particularly folk medicine.

Since the start of the training program, there has been a steady decline in the maternal death and stillbirth rates. The former declined from 7.7 per 100 live births in 1940 to 3.0 in 1966, and the latter from 4.4 to 2.1 over the same period of time. A large percentage of maternal deaths were in the 20–39-year age-group, and over 80% of the deaths were caused by complications at delivery (postpartum hemorrhage, retained placenta, etc.). For maternity care in the rural community, the plan emphasizes home

delivery, and the TBAs were utilized under close supervision of government nurses and auxiliary midwives. After the training program, which reached over 18,000 TBAs, it was expected that their new knowledge in modern delivery and child care techniques would help them conduct safer deliveries. Moreover, it was hoped that a closer relationship with government personnel would bring about more referred cases of difficult labour to the hospitals and health centres. Since the TBAs were trained, the maternal mortality and stillbirth rates appear to have declined more rapidly. In 1971, the Ministry of Public Health reported 2.1 and 1.3/100 births for maternal death rate and stillbirth rate respectively. When the Ministry of Public Health launched the National Family Planning Program in 1972, the TBA was considered a possible agent of change in the area of family planning. The pilot project was conducted to teach MCH/FP to a small group of TBAs, and assess, in working situations, their interest and ability to become a motivating force in acceptance by village women of family planning.

Objective

We will review previous and current work on the utilization of TBAs in the family planning program in Thailand, and consider possible areas and approaches for future research.

After the first training program in MCH in 1967-68, there was no follow-up evaluation made. Some surveys have been done to study the present KAP of the indigenous women toward the health services. The findings show a preference for the TBA. The studies were intended to support the public health planning program. For example, at present the NFPP with the assistance of UNFPA, is studying the feasibility of integrating FP into MCH in four northeastern provinces. Data¹ indicate that 40% of northeastern married fertile women prefer to have the TBA attend their deliveries, and 63% reported that the TBA attended her last delivery. These figures support the important role of the TBA in MCH/FP.

In early 1973, a project sponsored by IDRC was started jointly by the School of Public Health of Mahidol University and the National Family Planning Program. The objective is to evaluate various methods of inducing changes in the behaviour and attitudes of the TBAs in relation to the MCH/FP program.

This study will attempt to answer many questions. For example: 1) is it feasible to train the TBA for MCH/FP communication purposes and utilize her as an agent of change to motivate the eligible couples to use family planning services? 2) What are the results of the TBAs efforts in FP motivation in terms of her ability to recruit the new acceptors and to motivate present users to continue contraceptive practice? 3) What is the cost of the

MCH/FP training program, and what is the cost/benefit of utilizing TBAs in the program? 4) How can the TBA be motivated to recruit more acceptors and to follow up on the FP users with various types of incentive? 5) To what extent will the training program affect the utilization of TBAs in the MCH/FP program? 6) To what extent can the MCH/FP work of the TBAs be improved and extended through support from the community leaders?

Although the study is incomplete, the following general characteristics of the TBAs have been noted: The mean age is 56.5 years (range 40-74), and 50% are widows. Most are illiterate and their income is very low, most engage in the farm business, and attending births is only a part-time occupation. The mean number of pregnancies and live births is 7.5 and 6.8 respectively. Almost all favour family planning and are willing to learn and be trained, if possible. Their status in the community is high, and they provide a needed service. About 73% have been trained in the government/UNICEF.

The results of the study in rural Thai communities shows that family planning is quite acceptable and religion is not an obstacle. Most Thai Community leaders favour and support family planning.

We found that the TBAs could recruit young, poorly educated rural acceptors, and they were also effective agents for changes in attitude. Except for our project, there is no program in Thailand to use the TBAs in MCH/FP. However, as part of an intensive and comprehensive study of the health care program, the Ministry of Public Health encouraged TBAs to register for refresher training courses. They were regarded as one of the input variables for the project. The training program itself was evaluated but not this actual utilization of TBAs in the program.

Future plans include a training program for TBAs in both MCH and FP in an Accelerated Development of MCH/FP services project. The main objective is to integrate MCH with FP, and the study area includes four northeastern provinces. The study should

¹ Preliminary report, Baseline Data from MCH/FP KAP-Fertility survey: The study of integration of family planning within maternal and child health services; Research and Evaluation Unit, Family Health Division, Dept. of Medical Services and Health, Ministry of Public Health, June 1974.

clarify the effectiveness of TBAS as disseminators of contraceptive information, and distributors of supplies, and determine the best way to fit them into the organized health teams.

In addition to the traditional role of the TBAS (prenatal, postnatal and child care, referring of complicated cases to medical personnel, etc.), we now want them to disseminate birth control information and encourage people to attend FP clinics.

The TBAS could also possibly act as supply agents for contraceptives such as the condom and foam to assist the government distribution schemes. They might also assist the government personnel as rumour correctors, to bring the dropout acceptors back into the program, and protect potential acceptors from misbeliefs or false rumours about contraceptives. The TBAS might also be useful as "registrars" of vital statistics concerning births and deaths in her community.

The following questions must be answered before the TBAS can be fully utilized in an MCH/FP program: 1) to what extent are the TBAS able to motivate the potential FP users of a higher socioeconomic status? 2) what degree of support from the community would maximize the MCH/FP performance of the TBA? 3) what degree of supervision is needed from the government health staff? 4) how can they be trained and used in as rumour correctors and/or resupply agents and/or vital registration reporter? 5) how can we overcome the problem of illiteracy? 6) how can they be motivated to recruit more FP acceptors and promote longer continuation of contraceptive use? What will be the effect of incentives and other reward systems on the performance of the TBA? 7) do the TBAS initiate or spread negative rumours about the side effects of contraceptives? 8) what

is the relationship between MCH and FP services provided by the TBA? 9) to what extent can they influence potential male acceptors? 10) what is the difference between the attitude toward use of contraceptives by TBA and non TBA-motivated acceptors?

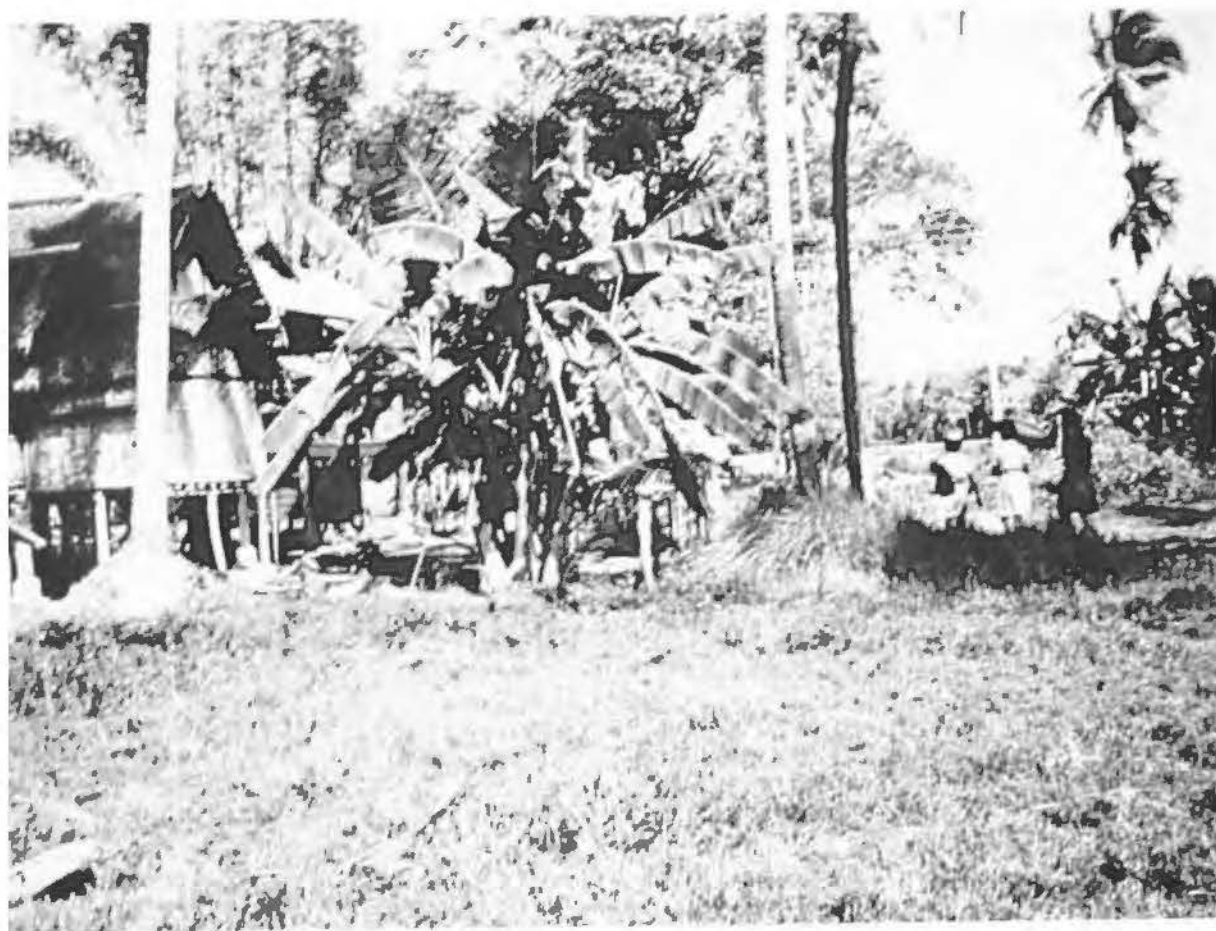
Conclusions

TBAS may be effective agents to disseminate contraceptive information for the young, eligible women in the rural, agricultural community. TBAS in Thailand have not been utilized except for the purpose of research in four selected areas. In the MCH program, training programs were conducted to improve the delivery care performance of the TBAS. The additional was required because of a lack of strong supervision and poor supply system as well as a lack of refresher training courses. They may not be well utilized in the area of MCH.

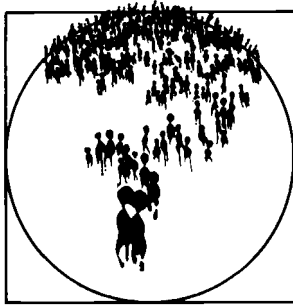
A number of research projects are planned to demonstrate the feasibility of utilization of TBAS. These will hopefully accelerate their more complete utilization in the MCH/FP program in Thailand in the future.

References

- KEOVICHIT, S., ET AL. 1974. The preliminary report on the study of utilization of moh-tam-yae in family planning program. Mimeograph No. 1 Research Report, Mahidol University, Bangkok, Thailand.
- SUVANAVEJH, C., AND U. SIRIVATHANANT. 1974. Characteristics of the new family planning acceptors recruited by moh-tam-yae and 1972 NFPP's new FP acceptor. R/E unit, Family Health Division, Mimeograph No. 2 Research Report, Mahidol University, Bangkok, Thailand (in press).



Health workers visiting village in Perlis, Malaysia



Outlook and Future Research in the Thailand TBA Program (Part 2)

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For the past several hundred years, the main function of the TBA in Thailand was delivering babies in the traditional way. When the Thailand Ministry of Public Health, with UNICEF assistance, conducted an MCH training program for TBAs, 10 years ago, they were expected to give expectant mothers the modern, correct technique of delivery and correct information regarding prenatal and postnatal care, and also child care. Moreover, they were instructed to refer problem cases or cases with complications to the nearest hospital or health centre for more sophisticated medical treatment.

In our study of TBAs and family planning, the TBAs had been receiving training in FP as well as MCH. Therefore, beside the above tasks in our project they are expected to disseminate contraceptive information to their clients as well as to motivate the potential acceptors to adopt a contraceptive method.

Our study is nearly finished and since we have learned more about TBAs, we do feel that there is a future for these people in our family planning program. In fact, we think we are underutilizing them, particularly the select group of younger, active, and educated TBAs.

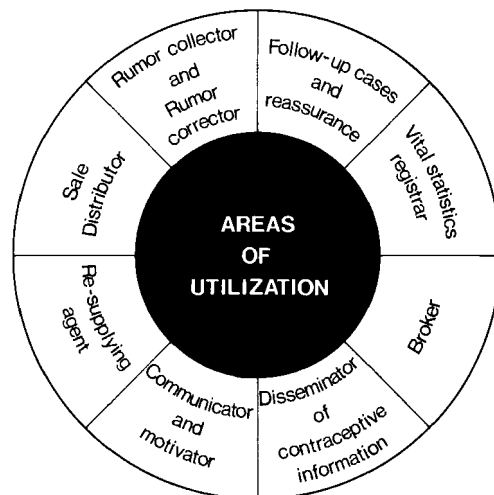


Figure 1

The possible areas in FP that TBAs might be utilized (Fig. 1) in the future are: (1) as resupply agent or (sales) distributor for some specific contraceptives such as oral pill, condom, and foam tablet; (2) as the rumour collector and reporter to government health personnel (they may be trained to correct those rumours as well); (3) for follow-up cases and reassurance on the facts of contra-

ceptive methods to bring back the dropout and protect the potential acceptor from misconceptions about contraceptive methods; and (4) because TBAs have been dealing with large numbers of births (and deaths) in the community they might be used as the vital statistics registrar to improve reliability and validity of the National Vital Statistics Bureau.

Questions Concerning TBAs

What degree of supervision from the government health workers would encourage the maximum work of TBAs and be mutually beneficial for both sides?

Discussion

The relationship between the government health personnel and TBAs is not too good or not too strong. Are there ways we could study the situation and see how this relationship can be strengthened through supervision? Are there other channels of supervision that should be created?

When you want to plan for supervision you must ask yourself four questions: First, who will you use as supervisor? I would like to point out that if the health personnel themselves do not get good supervision how can you use them to supervise the traditional birth attendants? In our research experience we have learned that most Poo-Yai-Ban (village headman) are in favour of FP and most had considerable knowledge about it. They know more about birth control methods than the TBAs. Therefore we feel we might be able to use the headman as the supervisor although they are under the Ministry of Interior. Family planning in Thailand has been declared a National Policy, therefore everyone should help (including any organizations that are related) the Ministry of Public Health to solve the population problem.

Other questions include: How they should be supervised? When should they be supervised? What matters should be most closely supervised?

How can TBAs be trained and used in the new roles (e.g. resupplying agent or sales

LEVEL OF TRAINING

OTHERS	FP	Able to prescribe household medicines
		Registration technique
GRADE 4 Rumor corrector		Able to identify rumor and overcome it
GRADE 3 Resupplying agent or sale distributor		Know how to use pills & condom: able to prescribe pill & condom
GRADE 2 Communicator & motivator		Know technique of motivation: able to motivate their clients to accept FP
		Know methods of birth control and side effects: able to advise and refer problem cases to clinic
GRADE 1 Disseminator of contraceptive information		Awareness: able to advise FP services available in the village
M.C.H.		Needed M.C.H. services: A.N.C., delivery, FP care and child care -- etc.

Figure 2

distributor, rumour corrector, vital statistics registrar)?

When considering training, we must first decide on the specific jobs we want them to do. Then we can plan a training course. Figure 2 illustrates the levels of training I recommend.

How much training will enable TBAs to perform their functions effectively? What group of TBAs should be trained and to what level?

As you can see in Fig. 2, I have included MCH training for the needed MCH services (e.g. prenatal care, delivery, postpartum care and child care at the lowest level) because I felt that MCH is the primary task of TBAs and all should be trained in this subject.

In the second level of training in FP I have divided it into four grades, because our research experience shows that not all TBAS can do well with our training (because of their advanced educational background, etc.). Therefore, utilizing them and planning the training, we should first classify them carefully, try to estimate their capability, then train them at the level that suits each individual.

Level 1 (or 1st grade) in FP is only to create awareness; e.g. to tell them that rapidly increasing population is the problem, having too many children and having them too close together could be a danger to health, that there are ways to prevent pregnancy safely, and that such services are available in their villages. If you train them up to this level you may use them as disseminators of contraceptive information.

Level 2 is for the more enthusiastic and active TBAS, who are better educated and a little brighter, to be trained in the methods of birth control and side effects, and techniques of motivation. We could utilize them as the communicator and motivator to recruit new acceptors for the FP program.

If they do well in Level 2, and seem capable of doing more, then we will upgrade and train them in higher levels (e.g. how to use pill and condom and then utilizing TBAS as resupply agents (or sale distributor) of both items).

The highest level of FP training I think, is the ability to identify which is rumour, which is side effect, and an ability to overcome the problem using the delicate technique of motivation by explaining the truth to the people.

If we plan to train TBAS this way, we do not need to exclude any TBAS from our FP program, unless they want to be excluded. With these different levels of training, every TBA can have a role in family planning. And before training them in higher levels, or upgrading them, we have to measure their performance. Therefore, if we classify them

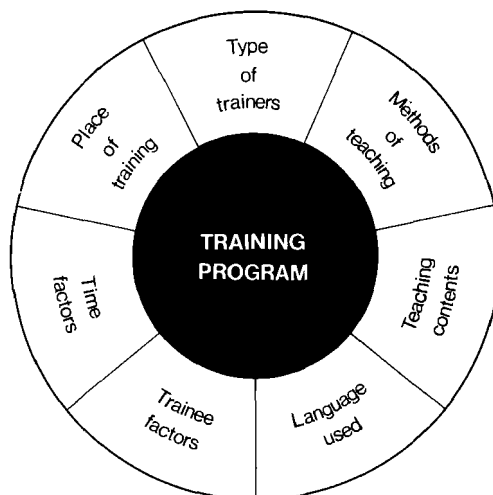


Figure 3

carefully before training, and measure their performance before upgrading, there should be no dropouts from the FP program because of poor performance or an inability to perform what we expected.

Although there was apparently no significant negative reaction from TBAS dropped from the Malaysian FP program because of poor performance, we are still concerned about this possible reaction of TBAS in Thailand. We do not want any enemies among the TBAS, simply because we assigned work beyond their capabilities.

How can we overcome the problem of illiteracy? In developing a training program, we have to consider several factors (Fig. 3). For example, the type of trainers: The possible trainers in the various subjects or various aspects of FP are the MDS, nurses, and midwives. They can train in the areas of scientific and technical knowledge.

The second trainer group is the TBA. They may help train their colleagues on the working experience as well as techniques.

Village headmen and other community leaders also could be used as trainers in the concepts of FP. By doing this we will have all of them in our program, thereby promoting

communication and support for the FP program.

Another factor requiring consideration is the method of teaching: The method will depend on knowledge or skill we want them to acquire. The methods found most useful are small group discussions, role-playing, demonstrations, audio-visual aids, question and answer sessions, and field practice.

The third factor is teaching contents: A specific objective must be defined before planning the teaching content. The language used must be the local language using only simple words.

Trainee factors include age, education background, attitude of TBAs, and the number in each training session (not over 25).

We should consider what *time of the year* the training should be carried out, how many days each training course should last, how long the sessions should be, and how often we need to have them back for refresher courses. And finally the training should take place in a warm, relaxing, informal and friendly atmosphere.

Final questions include: How can TBAs be motivated to achieve more FP acceptors and to promote longer continuation of contraceptive users with various types of incentives and other rewards? To what extent can incentive affect the performance of the TBA (Fig. 4)? What incentive should be used, how are they paid, when should they be paid, etc.

We classified incentives into two types: 1) *Monetary incentive*: money given as salary

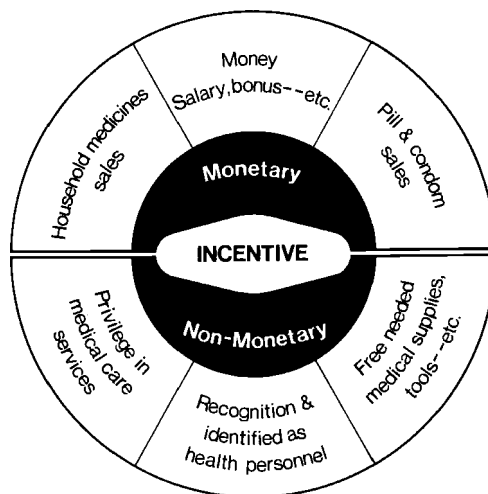


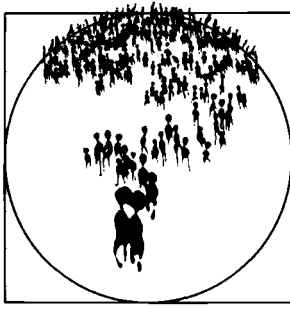
Figure 4

or bonus; commission from selling pill and condom; and commission from selling household medicines; and 2) *Non-monetary incentive* such as free medical supplies, tools, etc.; recognition and identification as health personnel; privilege in medical care services for TBAs and their families.

In Thailand we feel that we should emphasize the non-monetary incentive.

Conclusions

These research questions must be answered in the course of future research. We are bringing forward these issues to emphasize the areas of research that need further attention. We hope to have answers to some of these in the near future.



Outlook and Future Research in the Indonesian TBA Program

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BEFORE the Dutch colonization, the only health care available in Indonesia was provided by the traditional healer and midwives who had no training in medicine. During colonial times the Dutch rulers built health care delivery systems which were mainly for the Dutch people and their employers, and available only to a limited extent for the Indonesian people. The population therefore continued to receive services from the traditional medical manpower. During that time, two medical schools were founded in Surabaya and Jakarta, which produced low-standard physicians for the Indonesian population. After some years, these schools developed the Western standards of the medical school. In addition, there were several paramedical schools in several big hospitals in the large cities.

Although we have been independent since 1945, and have founded 12 government medical schools, we are still facing health manpower problems not only in numbers but also in the distribution and qualification of medical personnel. Related problems are low salaries, lack of facilities, and the widely dispersed population in the islands outside Java. Besides these obstacles we also face

the problems of poverty, illiteracy, and ignorance. Because of these conditions a large number of people still seek traditional health care to fulfill their needs (Table 1). These data reveal that almost half of the babies were delivered by the TBAs. This information was compiled by the Agency from its area which is 80% of rural areas.

The Role of the TBA

The TBAs when doing their work in the family, will become a substitute for the mother in managing the family's daily life for a period of 3–5 days. Her functions will be: (1) nursing the mother and baby, (2) managing the whole family, and (3) act as an adviser for some aspects of the family affairs especially in fertility. They may receive money or goods in return for such work.

The services are individualized and personalized according to the needs of the individual family. In some villages where there is no trained midwife the villagers still come to the TBA for these reasons.

FP Program in North Sumatra

Family planning as a method of controlling the population growth has been accepted

TABLE 1. Number of babies attended by midwives, midwives auxiliaries, and traditional midwives in Asahan Regency, 1973.

Month	Midwife	Midwife auxiliaries	Traditional midwife
Jan.	83	81	194
Feb.	79	85	161
Mar.	107	83	198
Apr.	80	96	160
May	75	112	170
June	113	104	194
July	75	103	182
Aug.	94	119	181
Sept.	100	135	168
Oct.	94	116	185
Nov.	84	129	175
Dec.	115	99	161
Total	1098	1233	2150

Sources: Yearly Report of the Activities, 1973, Health Services of the Asahan Regency of North Sumatra.

officially by the Indonesian government. The administrative agency coordinating all activities related to the family planning was installed by President Soeharto in 1969, and it was supported by the Indonesian Planned Parenthood Association in research and training. During 1969-73 the activities were limited to Java, Madura and Bali Island, but now it will cover all of Indonesia, including North Sumatra.

This will put the responsibility for the success of the family planning program in the provincial BKKBN. This agency and the health unit of North Sumatra lack sufficient experience and manpower to implement the program. They have to use available manpower without any further training in family planning.

The TBA has considerable influence in rural family life so we must recruit them and encourage them to participate in the family planning program. Because the family planning issue is new, because there is urgent

national need to reduce the population growth so that any achievement in economic development will not be consumed by the increasing population, we have to plan carefully. The recruiting program and the roles which will be assigned to the TBAs must be carefully planned. Failure of the family planning program will be a disaster to our nation.

Role of TBA in FP

As mentioned before, 80% of the population live in the rural area and almost 50% of the births are attended by the TBAs. Their role in the rural family can contribute to the family planning program.

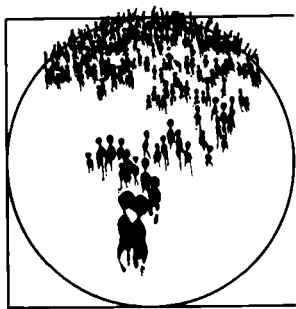
It is therefore essential that the family planning organizer and administrator integrate the TBAs into the family planning program, especially in the rural areas.

Many of the TBAs are old and illiterate and earn their living by helping the delivery of babies. The role of the TBA will be to identify, to motivate, to recruit and follow up the acceptors of the family planning program.

Many of the TBAs will be concerned that success of the program will mean an end to their livelihood, so we must provide sufficient incentive to overcome this concern. This must be pursued cautiously and tactfully.

Further Research

Before any recruitment and training of the TBAs takes place we propose to make several studies: (1) the real role and function of the TBA in influencing the people and the social acceptance of family planning; (2) the level of education, knowledge and attitude of the TBA toward the family planning program; and (3) the effectiveness of the utilization of the TBA in the family planning program by continuous evaluation (i.e. the number of acceptors referred by them).



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, piece-work 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

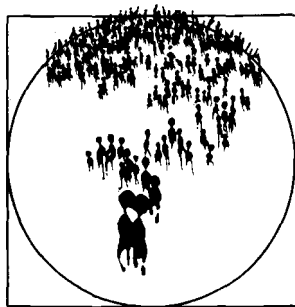
utilize them in the best organized way for both MCH and FP. I would also like to propose establishment of a channel for regional cooperation among countries in Southeast Asia for this type of program. How we organize, how we can carry out the program in a somewhat standardized way, and how we can develop 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.

References

- CHEN, P. C. Y. 1973. An analysis of customs related to childbirth in rural Malay culture. *Trop. and Geogr. Med.* vol. 25.
- NATIONAL FAMILY PLANNING BOARD. 1968. Report on West Malaysian family survey, 1966-1967. National Family Planning Board, Kuala Lumpur, Malaysia.
- NATIONAL HEALTH COUNCIL. 1965. A study of the maternal and child health service in the states of Malaya. Maternal and Child Health Committee, Kuala Lumpur.
- PENG, J. Y., NOR LAILY BTE. A. BAKAR, AND ARIFFIN BIN MARZUKI. 1972. Village midwives in Malaysia. *Studies in Family Planning*, vol 3, no. 2, February.



Typical rural village in Perlis, Malaysia



Outlook and Future Research in the Philippines TBA Program

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THE four countries involved in this seminar (Indonesia, Malaysia, the Philippines, and Thailand) agree to the recognition of traditional birth attendants (TBAs) as indispensable deliverers of health care in a general situation of continuing rural mass poverty; and the policy of working toward legitimate recognition and program utilization is essential in such activities as registration, and the provision of training whether for maternal and child health, family planning, or both.

All four countries have done general survey-type research to develop a profile of TBAs. In these studies the usual information gathered includes: age, education level, family size, remuneration practices, births attended per month, and in some cases special questions on the KAP of family planning and customs in child delivery are described.

In cases where training has been tried whether to upgrade delivery practices or to entrust them in a new role as family planning information and referral agents, a tendency has been observed for TBAs to revert to traditional practices or in the case of their newly designated task, to move from high to low levels of performance.

Beyond these usual surveys, each country has done some studies to pilot test training

schemes, supervision procedures, modes of payment and other factors that might contribute to making the TBA an effective extension worker in family planning. Malaysia has a scheme whereby the registered midwife works with the TBA while training.

Future Role of TBAs

The potential role of the TBA is perceived differently by various countries. Malaysia aggressively attempts to emphasize the family planning role of not only recruiting acceptors but in resupplying contraceptives. Thailand, the Philippines and Indonesia have carried out similar studies in utilizing such workers as motivators but without handling contraceptives. More studies are needed to confirm the extent to which additional tasks can be expected of TBAs.

Given the above, it seems that there is an answer to the question raised at the seminar: "Is there a future for the Traditional Birth Attendant?" The answer must be *Yes*. The future of the TBA in each country will depend on the vision and aggressiveness of program administrators to try new strategies. It will depend on the sensitivity of planners to learn and get clues from neighbouring countries whose culture and problems are in many

ways similar. The question is no longer whether they are trainable, changeable, and utilizable. Rather the question is how best to train, how best to supervise, how best to utilize, and for what purpose. The future can certainly be steered if not fully controlled. And this is where evaluation research plays a significant role. The testing of new ideas, if scientifically designed, is believable to policy-makers and one can expand plans with greater confidence. However, the conduct of experimentation must be within the realistic boundaries of government budgets. Otherwise, we stand to prove something we cannot afford to implement.

Further Studies

I have listed a number of study areas that seem to need further attention. However, only individual countries would know what research is needed within the context of its own problems.

There is need for sociological studies that look into the dynamic relationship of TBAs to the community and other health workers.

We need to do small, manageable types of studies that experiment on alternative procedures to make the TBA accept with some continuity her modified role and identify what reasonable output can be expected from her. Such studies as those in Thailand, Malaysia, and the Philippines should probably be replicated in other areas of the country.

Continued work on the methods and degree of training is necessary.

I think a systematic study on the harmful and harmless practices would be useful in identifying entry points in changing the TBA.

We must know more about the attitudes of the medical community and government officials in the use of TBAs, for example as family planning motivators and resuppliers, or even as legitimate deliverers of health care.

Problems in the use of TBAs for family planning found in most studies conducted so far seem to be similar to the problems we

have been facing on the use of lay motivators in the Philippines. To what extent can we expect any more from TBAs in their motivational outreach when they are like any other change agent faced with problems like: environmental factors (distance, season (weather) variations, etc.); attitudes of clinic staff; imperfection of technology producing undesirable side effects; and rumours that are difficult to counteract.

Thailand categorized these problems with environment, health workers, acceptors, and TBAs themselves.

I challenge the hypothesis that the high status of the TBAs amongst the villagers would make them any more effective than a lay motivator. Why should they be more effective? In fact, they have two sources of income: birth delivery and birth prevention, both of which oppose each other.

The Thailand study showed that monetary incentives were not attractive to the TBAs. Why is this so?

The Indonesian conclusion provides us with thought-provoking hypothesis that "individual approach" in family planning communication could make use of TBAs. However, a "mass approach" would probably diminish the role of TBAs. Other countries might wish to explore this further.

The problem of supervision brings us to the area of management research. We made a study of high-performing clinics versus low-performing clinics and we looked into management factors such as the supervision of motivators by the clinic doctor. The suggested scheme on who, how, what, of supervision suggested by Thailand might be operationally tested.

The Malaysian study called attention to the problem of large dropouts of trained TBAs from family planning involvement. Here again, has enough research been done to lead us to believe that we simply have to establish priorities both in selecting areas, and in selecting which TBAs should be utilized for FP

while provision of FP orientation is given to all.

Field trials should show what tasks TBAS can be asked to perform to meet family planning objectives.

From such a study, some educational program might be developed that will transform the more progressive TBAS to be professional midwives.

I will now discuss a specific research project that we are presently refining with the implementors. Dr Fe Del Mundo has consented to be the principal investigator. Briefly, 75 TBAS in the experimental sites will undergo a 6-day training in the procedures of pill distribution by the checklist method and the use of coupons for resupply. This training is in addition to what has been provided presently in maternal and child health (MCH) and family planning for 4 weeks. They will be allowed to charge a fee of no more than PO.50 per cycle.

The objective of the study is first to deter-

mine the safety of utilizing TBAS for the pill prescription method without prior examination by a physician. Second, to determine its effectiveness in helping get new acceptors, improve continuation rates, and make referrals.

The research is designed to compare the performance of TBAS regularly trained in MCH and FP in control areas to the TBAS in experimental areas who will be given the extra 6-day training.

The project will last 9 months. Analyses of records will be done after 6 months. However, a survey in the ninth month will be conducted to determine continuation rates.

This study is somewhat radical and is bound to raise some eyebrows. But as I said, the future can be steered to some extent and operational research is a convenient tool to show us the path.

There would probably be great value in having a follow-up seminar at some future date to further evaluate the various country family planning programs utilizing the indigenous traditional birth attendant.

Discussion Summary — Session IV

Rapporteur: Dr T. Mayhandan

- 1 It was generally agreed that the TBA can be effectively utilized for FP. Pilot projects in Thailand and the Philippines and the practical experience of Malaysia in this field are very encouraging.
- 2 The following require further study: cost effectiveness, type of training, utilizing in other health programs such as MCH, ways of organizing, determining length of time TBAs would be of practical values to a FP program, availability of supervision, and the future policies of government toward TBAs.
- 3 The Malaysia and Thailand participants felt that future research should be conducted on the role TBAs are expected to play in FP. However, the research proposal of the two countries differ in method of approach to the problem. In Thailand the use of the TBA is as a "change" agent and therefore their future research and outlook is based on converting this motivating agent into a functional FP worker.
- 4 Indonesia at present is studying the role of functions of the TBA in influencing the people, the social acceptance of FP, and the level of education, knowledge, and attitude of the TBA toward FP and their effectiveness in this program.
- 5 Since there was unanimous agreement on the positive utilization of the TBA in FP, and since the problems are the same throughout the region, a regional planning approach was proposed for the cooperative exchange of experiences and ideas, and to develop the program directly in accordance with the needs.

Session IVa

Discussion Reports and Final Recommendations

Epilogue

The final session of the seminar was devoted to discussion, in three separate groups, of three main topics concerning the utilization of TBAS.

Topic I included the identification of the positive and negative factors in the use of TBAS for FP: should they be used as well in maternal and child health services, and if so, what would the positive and negative factors be. The final question under this topic was: Is there a future for this type of personnel in national family planning programs?

Topic II included discussion of the following questions: what functions should TBAS be asked to perform; what system should be designed for the operation; how should TBAS be recruited and trained; should there be optimum performance targets; how should they be paid; what supervisory channel should be established for an effective operation; how should individual performance of TBAS be assessed, and how can their morale be kept high?

Topic III concerned the need for regional cooperation in the planning, operation, and evaluation of utilization of TBAS in family planning, and how best this regional cooperation could be developed.

Each group appointed a rapporteur, and the reports of the three discussion groups follow.



TBAs listen attentively to instructions during training periods

Group I Discussion

Dr T. Mayhandan, Rapporteur

It was decided to discuss the second part of Topic I before embarking on the first part in order to take into consideration the varied experiences from the different regions.

It was generally agreed that TBAS should be utilized in FP and then MCH, not vice-versa.

Positive factors identified by the discussion group are:

1) Training of TBAS is an attempt to reduce the hazards in the rural areas (e.g. maternal mortality, infant mortality, etc.).

2) If TBAS are properly utilized after training, we can narrow the gap between available trained health personnel and the rural population in FP/MCH activities.

3) TBAS are influential persons who can provide a service (e.g. helping in the house) which is not part of the routine functions of the trained health worker.

4) The TBAS, by virtue of their position in society, will be able to combine religion, culture, and "modern concepts in scientific knowledge" in the promotion of FP/MCH. The uniformed staff are unable to do this at present due to a lack of rapport with the rural people.

5) From the national family planning program point of view these activities do not entail much expense.

The following *negative* factors were identified:

1) The TBAS lack proper education and training in FP/MCH work. Some are physically handicapped due to old age, and in a heterogeneous society (e.g. Sumatra), their use may be limited due to different ethnic groups involved.

2) Those TBAS who have been selectively trained for FP work may compete with the fully trained government workers.

3) Those TBAS who have not had the benefit of selective training programs may misrepresent the FP program.

The Future

In Malaysia, utilization of TBAS has proven to be of considerable value in FP, but adequate incentives are necessary.

Thailand's pilot studies, however, show that monetary compensation is not of any significance. No such studies have been conducted in Malaysia.

Indonesia, though recognizing the positive value of TBAS in FP work, is not utilizing them actively.

In the Philippines, TBAS act as extension arms of the FP/MCH services with the cooperation of the health personnel.

The general consensus is that there is a place for TBAS in the extension and implementation of the national family planning programs of the various countries in this region.

The TBAS may be used as a functional worker, a motivator, supplier, a tracer of defaulters, a referral agent, reporter of false rumours, and registrar of births and deaths.

Firm government policy and support is necessary for the success of the system using TBAS. The Malaysian system would probably be suitable and operationally feasible.

We should recruit all available TBAS and make them aware of, and motivate them toward, the FP/MCH program. Selective training is necessary for suitable TBAS for FP work.

It would be difficult to set optimum performance targets. It depends on the areas where the TBAS are stationed. Basic statistics must be available before targets can be set.

Some sort of payment or incentive is necessary. The Malaysian system is quite effective and may be used as a model for application in other countries, with modifications. Funds may be obtained from various government institutions, the private sector, and international bodies.

Supervision should be carried out in collaboration with local health workers and with cooperation from other levels. There should also be cooperation at state level, and with political heads at the village level.

Support for TBAS is evident by the recognition of their role in FP/MCH activities and by periodic visits of high-ranking officials. High morale could also be maintained through training programs and visits within their own country.

The participants unanimously agreed that regional cooperation is possible and very necessary in the planning, operation and evaluation of the TBAS in FP.

Annual or biennial international and internal collaboration in the form of seminars may be held regularly but one should guard against setting up yet another superstructure. Policy planners should be included in the implementation of the FP program and representatives from various political and cultural organizations should be invited to attend FP meetings, seminars, and conferences.

Group II Discussion

Dr Flora B. Bayan, Rapporteur

From the outset, the group accepted the fact that since 40-50% of deliveries in the rural areas, in our region, are still being attended by the TBAS, their utilization for MCH programs is inevitable at this point in time. And, it is precisely because of their long and established involvement in maternal and child care especially in rural areas that their potential roles in FP is being brought into focus.

In considering their possible usefulness to MCH/FP programs, certain positive and limiting factors have been discussed to make us all aware that they do exist and that these factors should be given careful thought in planning for their utilization.

The group identified the following *positive values*:

1) They have established long and intimate family ties and relationships not only with the pregnant and parturient members but with the older and younger groups and can therefore exercise influence.

2) They are closely associated with health activities and therefore possess credibility in these aspects and could be well accepted as auxiliaries to health workers and in the delivery system of health care.

3) They can serve as liaison between community and health centres.

4) Her simplicity of approach and her knowledge of folk environment makes her an effective communicator.

5) As one who provides low-cost medical services, she fits quite well into the socioeconomic pattern of the rural situation and population.

6) Because of her accessibility and availability, she can therefore maintain and sustain motivation for family planning practice.

7) Her personalized service is also appreciated in rural areas and this is especially where the human touch of TBAs can best serve in MCH/FP.

On the other hand, there are factors which could limit their effectiveness, e.g.:

1) *Low educational level* Because of this, they will require refresher courses and the provision of information to keep them well motivated.

2) As pronatalists, their new role as promoters of FP may give rise to conflicting values.

3) They do not cover other villages and therefore their field of contact can be limited.

4) FP activities may be interpreted as a reducer of their income.

5) Conflict could develop between trained midwives and TBAs as a result of the recognition given to them following their training. Kits and certificates may lead them to presume that they can perform jobs which are beyond their competence, and which may annoy the government midwives. Other government workers may claim that they are being given undue recognition by the government although it is admitted that their services are still very much in demand.

6) Because they are involved in other work such as farming, household chores and as parents themselves, they may not have the time to be effective workers.

However, despite all these limiting factors, the group recognized the fact that they are here and should be involved in FP programs.

Other positive factors which were considered in regard to their involvement for MCH/FP programs were also mentioned: 1) Constant contacts with mothers provide good opportunities for supervision in MCH activities; 2) They can also be utilized in upgrading our birth and death registration; 3) As community liaison, they can serve as "town criers" for health activities or as mobilizers for rural and community assemblies. Their involvement in the FP program can also add to their influence and prestige thereby improving their MCH activities.

The group believes that there is a future for this type of personnel in national FP programs but that they would probably be more effective if they were to be utilized in hard-to-reach areas, or where there exists shortage in manpower resources, and where the number of practicing TBAs is considerable.

What functions should the TBAs perform for FP? a) Motivators and information disseminators; b) Referral agents to medical practitioners and health centres; c) Liaison between acceptors and clinics; d) Resupply depots where there is no government agency or organization which can serve as such. This scheme will naturally vary from one country to another. For example, in Malaysia, the TBAs are relatively younger and with no

boundary limits to their activities, whereas in Thailand, they usually do not cross boundaries and areas.

What system could be designed for the operation? It was our opinion that they should not be made a part of the official system of health care except in preparing them through training and supervision to become better MCH workers and effective FP motivators as the case may be. It is also important to recognize them as members of the team and as promoters of health.

How do we recruit and train the TBAs? The group unanimously felt that while all should be trained for MCH/FP, their individual or direct involvement in FP should be by a process of selection by interview, or through time which, by follow-up and observation, will allow for identification of those who are interested in or possible motivators for FP.

What would be an optimum performance target for TBAs? The group does not endorse the use of targets as indices for performance. Not only do they give rise to falsification, anomalies or corruption but existing constraints vary from place to place. A TBA who recruits only small numbers of acceptors does not necessarily mean that she is ineffective.

The group felt that *paying* TBAs has many implications and can give rise to other problems as well. For example: When assistance to such payment schemes comes from foreign sources, the question of absorbing them into national budgets poses great economic problems not only in terms of other program priorities given by governments but also from the fact that government employees who are now clamoring for salary increases will not favour subsidizing TBA programs; to give salaries means to make them official personnel in government which will call for other provisions allotted to all employees; other studies and projects (in Thailand) have shown that providing training for them and giving them due recognition may be all that is necessary. Others suggested the reimbursement of actual expenses only. If monetary payments cannot be sustained as a continuing scheme, it may boomerang on the program itself. It was however cited that Malaysia, by virtue of its being a statutory body and special because of its structure and avowed priority to the FP program, is committed to pay TBAs. Whether other governments can will depend upon their ability to absorb such an undertaking in the face of other socioeconomic conditions.

On the question of *supervision*, it was admitted and agreed by all that supervision is of paramount importance, but that there is also a need at present to strengthen and improve supervisory channels and mechanics in existing health infrastructures. Bad supervision is worse than not having any at all. Training programs for health workers should establish this need and should take cognizance of the fact that health workers are being assisted by the TBAs and that efforts should be made to make them feel that they (TBAs) belong to the team. The TBAs should be given full support by the health personnel. Improvement of this relationship through periodic meetings, close contact, and association with TBAs is recommended. This too can bring about a raising of the morale for the TBAs and can keep them under closer guidance and supervision.

Their performance as TBAs is, in some areas, measurable by the number of referred FP acceptors who are serviced in FP clinics, and the number of follow-ups and defaulters who are remotivated to practice FP.

But where there are no targets involved their individual contribution to the programs in terms of motivation and as promoters of FP may be sufficient. Their ability to assuage complaints and rumours is important in rural FP activities.

While programs need targets, the group does not favour requiring the TBAS to meet a specific number of recruited FP acceptors.

Regional cooperation for planning, operation and evaluation of utilization of TBAS in FP is not only possible but desirable. The means may be through exchange in experiences, ideas, and project direction; and through field trips and seminars and documentary films of country TBAS.

However, the group felt that it will be difficult to establish such cooperation on a project basis because of the many variables existing in each country and region.

Group III Discussion

Ms Aurora Go, Rapporteur

The following *positive factors* in utilizing TBAS for FP were identified by the group: a) high status and credibility enjoyed by the TBA in the community due to long-standing contact and source of advice by families regarding maternal and child care, service provider in birth delivery, masseur, marriage broker, etc.; b) any additional training over and above present role of TBA gives a further boost in her status; c) TBA speaks the language of the people and understands the sociocultural, sociopsychological orientations of people she lives with and this is an advantage in communications; d) most TBAS are females and this is an advantage in relating to wives; e) however, TBAS must be acceptable to both husband and wife and therefore approach of both husband and wife is an important FP strategy; f) TBAS are usually invited to important family ceremonies such as birth, funeral, weddings, and this is a potential occasion for TBAS to work with the people; g) the age of TBAS can work to their advantage considering the traditional respect for elders; h) TBAS simply have a convincing manner of approaching and talking to people.

The *negative factors* were: a) while older age may be a positive factor, not all TBAS are utilizable. Although younger ones tend to be more effective for FP (new administrative tasks are difficult to remember by older ones) not all young ones will necessarily be effective; b) illiteracy limits any attempt at training and implementation. Training approach and continued follow-up supervision are essential.

In general, TBAS can be utilized for FP work as well as for MCH services. The problems in utilizing TBAS for both MCH and FP include a conflict which can arise between government midwives and the newly trained TBA (in MCH/FP), who often assumes an air of confidence and expects recognition as a qualified paramedic. The positive factors include the integration of MCH and FP, which is advantageous to FP. We can reach more rural mothers in using TBAS for both MCH and FP.

What is the future of TBAS in national FP programs? Since most governments have a drive to generate more qualified health personnel, TBAS will eventually be replaced. The future is optimistically bright in that there are clear indications of their utilizability. However, what is not so clear is the extent of their potential roles which can range from simple motivation to referral tasks to suppliers or prescribers of contraceptives. What they will be used for depends on needs of each country and the specific needs in the villages.

What functions should we ask TBAs to perform? Each country has its own experiences. Malaysia has tried and succeeded in using them for information-motivation plus resupplier. The Philippines intends to try this out while Indonesia at present is simply in favour of information and referral agents. Thailand uses them as motivators but not as resuppliers. Thus, it seems that each country should test out what functions can be given to TBAs. How far one can go can only be decided after testing. With the experiences of others, each country can have more confidence in trying them out.

The use of a coupon system seems good for evaluation but requires more administrative staff. The coupon as designed in Malaysia requires no writing from the illiterate TBA.

Not all TBAs should be trained, and community leaders or health personnel can be a good source of recommendation as to who should be trained. In selecting TBAs for training, we should consider their age and the number of deliveries they have attended.

The training period will differ for TBAs. Those untrained in MCH will require a longer training period and those with MCH training a much shorter period (e.g. Malaysia 3 days, Thailand 4 days, Philippines 1 week). The group should be no larger than 20 TBAs. A practical approach is required utilizing role-playing and visual aids. We should eventually standardize training by developing manuals for trainees.

Training should be given by nurse/midwives who will supervise TBAs throughout training. Project administrators should also be involved. Thailand and Malaysia use a live-in approach whereby TBAs stay in the training place.

If TBAs are good, targets can be set. In Malaysia and Thailand where targets were set, the average was 2. In Indonesia and the Philippines where no targets were set the average performance was again 2.

Malaysia gives "allowances" plus a bonus of M\$30. In Indonesia and Thailand "incentives" per type of acceptor are given. No recommendations were made on how best to pay (flat rate basis with bonus or penalty, or whether per unit of performance output).

A meeting should be held at least once a month, and supervisors should visit the TBAs at irregular intervals. All TBAs should have a permanent supervisor.

To keep high morale, and to give due recognition, we should occasionally choose a "Top TBA" in terms of performance and grant an additional bonus. Visiting VIPs in town should try to visit the homes of TBAs, which would greatly enhance their morale and prestige in the community.

Possible regional cooperation is definitely possible. Each country should designate a liaison officer for this activity from within the office of the national program for family planning. With available funds, further co-ordination and cooperation could be organized. A steering committee should be created from participants of this workshop to act as an interim committee to follow up the development of programs for TBAs in the various countries. The functions of this organized intergovernmental effort would be to share information on plans, encourage implementation in one country through the example of another, and to encourage research.

General Recommendations

The participants made the following recommendations:

- 1 TBAS in each country should be utilized for family planning/maternal and child care programs. Such utilization will not only accelerate the FP program but will also improve and broaden the coverage of the MCH program.
- 2 It was also recognized that there is a need for each country to state an official position concerning the utilization of TBAS for family planning, if they have not already done so.
- 3 All TBAS should have general training in MCH/FP, but it is not necessary to have all TBAS directly engaged in FP. TBAS for the FP program could be selected according to local needs and the suitability of the TBA.
- 4 There must be a good supervisory system established to monitor the MCH/FP work of the TBAS.
- 5 It would be useful to have regional cooperation for planning, operation and evaluation of utilization of TBAS in family planning. It was agreed that an individual with the national programs be designated to maintain contact and act as a liaison without official budgetary or administrative constraints. It was further agreed that Mahidol University serve as a clearing-house for information regarding research, evaluation, and implementation of programs utilizing TBAS in family planning/maternal and child care.

Recent IDRC Monographs

- IDRC-023e Directory of food science and technology in Southeast Asia, E. V. Araullo (compiler), 194 p., 1974.
- IDRC-024e Triticale: proceedings of an international symposium, El Batan, Mexico, 1-3 October 1973, Reginald MacIntyre/Marilyn Campbell, ed., 250 p., 1974.
- IDRC-025e, f, s AGRIS and the developing countries: recommendations of the FAO/IDRC meeting held in Rome, 26-28 September 1973; AGRIS et les pays en voie de développement: recommandations de la réunion FAO/CRDI qui s'est tenue à Rome du 26 au 28 septembre 1973; AGRIS y los países en desarrollo: recomendaciones de la reunión del FAO/CIID celebrada en Roma del 26 al 28 de Setiembre de 1973, 35 p., 1974.
- IDRC-026e Food crop research for the semi-arid tropics: report of a workshop on the physiology and biochemistry of drought resistance and its application to breeding productive plant varieties, University of Saskatchewan, Saskatoon, Canada, 22-24 March 1973, Michael Brandreth, 16 p., 1974.
- IDRC-027e Technology policy study centres in Africa: report on the IDRC/ECA meeting on the creation of centres for technology policy studies in Africa, Ile-Ife, Nigeria, 5-10 December 1973, 35 p., 1974.
- IDRC-027f Centres d'étude des politiques technologiques en Afrique: rapport de la réunion CRDI/CEA sur la création de centres d'étude des politiques technologiques en Afrique, Ile-Ife, Nigeria, 5 au 10 décembre 1973, 42 p., 1974.
- IDRC-028e Rural water supply and sanitation in less-developed countries: a selected annotated bibliography, Anne U. White and Chris Seviour, 84 p., 1974.
- IDRC-029e International Development Research Centre programs in agriculture, fisheries, forestry and food science: reviewed at a symposium, Ottawa, 12 September 1973, 55 p., 1974.
- IDRC-030e, f Publications of the International Development Research Centre 1970-73/Publications du Centre de Recherches pour le Développement International 1970-73, 24 p., 1974.
- IDRC-032e The first 200 projects, Claire Veinotte, ed., 38 p., 1974.
- IDRC-032f Les premiers 200 projets, Claire Veinotte, ed., 39 p., 1974.
- IDRC-034e Tsetse control: the role of pathogens, parasites, and predators (Report of a scientific advisory group convened at The Memorial University of Newfoundland, St. John's, Canada, 25-29 March 1974), 22 p., 1974.
- IDRC-034f La lutte contre les tsé-tsé: le rôle des pathogènes, parasites et prédateurs (rapport d'un groupe scientifique consultatif réuni à l'Université Memorial de Terre-Neuve, St. Jean, Canada, 25-29 mars 1974), 23 p., 1974.
- IDRC-035e Whilst time is burning: a report on education for development, J. Roby Kidd, 120 p., 1974.
- IDRC-036e Current trends in cassava research, Barry L. Nestel, 40 p., 1974.
- IDRC-037e Study-service — a survey: prepared as a background paper for research into various aspects of study-service, Diana Fussell and Andrew Quarmby, 44 p., 1974.

