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Traditional Birth Attendants
in Family Planning

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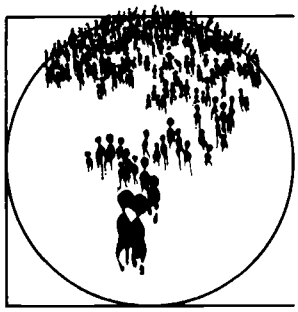

Outlook and Future Research in the Thailand TBA Program (Part 2)

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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.

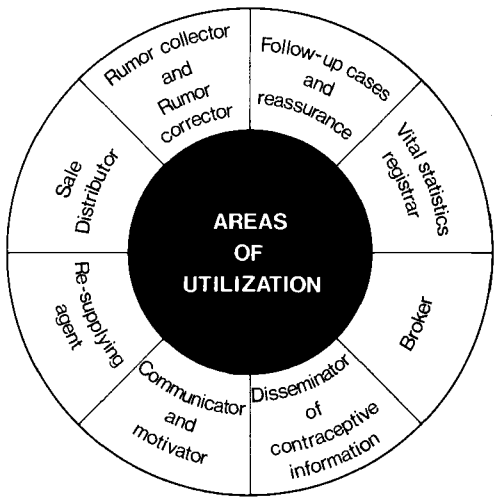

Figure 1

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 distributor, rumour corrector, vital statistics registrar)?

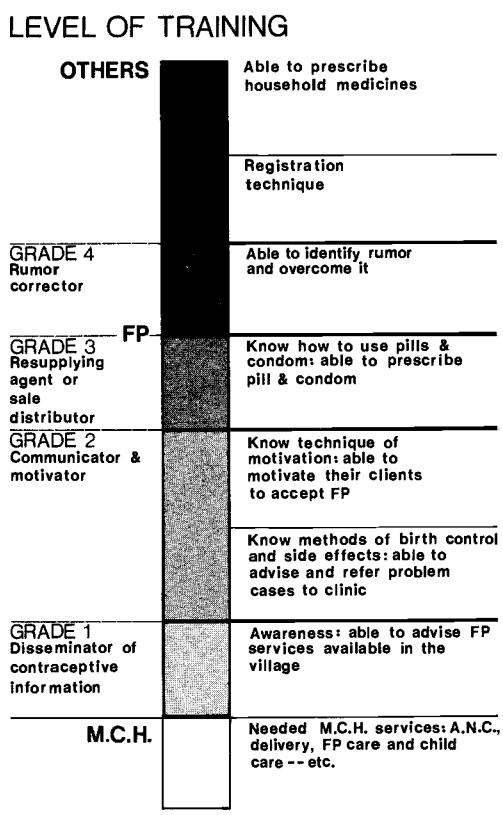

Figure 2

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 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.

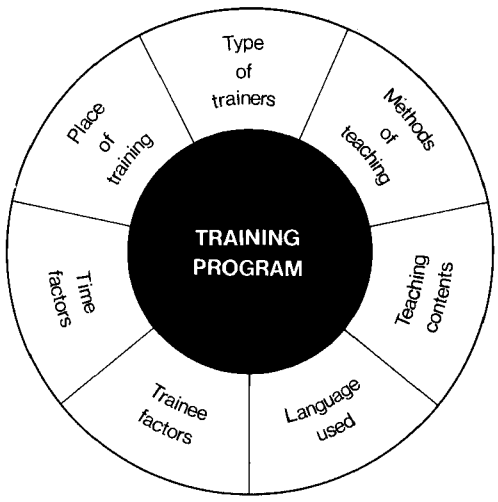

Figure 3

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 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.

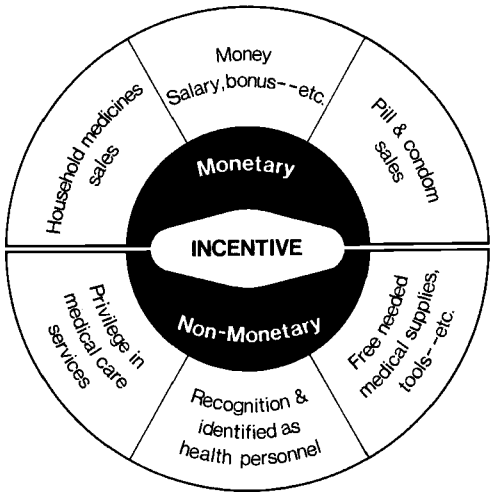

Figure 4

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.