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ABSTRACT

The publication provides guidelines for assisting developing countries in determining strategies for the utilization and training of traditional birth attendants (TBAs). TBA's are persons (usually women in rural areas) who assist the mother at childbirth and who initially acquired their skills through experience rather than formal training. After a chapter giving the results of a World Health Organization survey of birth attendants in various contries, it describes the formulation of strategies for TBA involvement in maternal and child health and family planning programs. It outlines a suggested training program (including learning objectives and tasks for antepartal, intrapartal, postpartal, and infant care, family planning and coordination with health services) stressing that the course should be adapted to the needs of individual TBAs. The publication deals also with the preparation of trainers and supervisors and with the problems and techniques of supervision. It ends with chapters on evaluation and on topics that call for further investigation. Each chapter is followed by a list of references. Appended are: titles used to designate TBAs, statistics on supervision of deliveries in various countries, analysis of existing training programs for TBAs (20 countries, 1972), national workshop questionnaire on activities of Indonesian TBAs, and suggested tasks of the trained TBA working in collaboration with the health establishment. (Author/MS)

THE TRADITIONAL BIRTH ATTENDANT IN MATERNAL AND CHILD HEALTH AND FAMILY PLANNING

A GUIDE TO HER TRAINING AND UTILIZATION

MARIA DE LOURDES VERDERESE AND LILY M. TURNBULL

WORLD HEALTH ORGANIZATION
GENEVA, 1975

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A guide to her training and utilization

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The national and international staff who participated in the Consultation on the Role of the Traditional Birth Attendant in Maternal and Child Health and Family Planning, held in Geneva in March 1973, through their personal experiences, insight and ideas, made a valuable contribution to the further development of the project and the preparation of this document.

Thanks are also due to the national and international staff who participated in the follow-up seminar and meetings held to review the guide and to elaborate the strategies, task analyses and training programme.

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PREFACE

Among the various problems that health administrators in most countries face in connexion with the development of their health care systems, one of the most difficult and currently unresolved, concerns coverage of the population in rural areas.

The available statistical information discloses that large numbers of highly vulnerable members of society, such as child-bearing women, infants and children and those exposed to a hostile environment characterized by the prevalence of communicable diseases, poor sanitation, and the harsh realities of a subsistence economy are also beyond the reach of the centrally organized health care system. In such areas there is a strong dependency on the locally organized or traditional health care system, of which the Traditional Birth Attendant is one of the principal elements.

A report based on a worldwide survey of Traditional Birth Attendants and their involvement in maternal and child health and family planning, the objectives, methodology and findings of which will be found in Chapter 2 of this document, was reviewed by a Consultation of Experts, who recommended that an in-depth review of the problem should be continued and that guidelines for the planning, implementation and evaluation of training programmes, supervision of Traditional Birth Attendants, and the identification of problems for future research should be prepared.

The present document has been prepared with the hope that health administrators, educators, and other health workers will find in it some suggestions which might be useful in reviewing and evaluating their programmes or developing new ones, and in forming a meaningful link between the traditional or locally organized and centrally organized health care systems. Such action will, it is hoped, result in more meaningful community involvement in the development of the health care system and in the extension of health care coverage through optimal utilization of local resources.

CONTENTS

INTRODUCTION

1. Objectives of maternity care

In 1966 the WHO Expert Committee on the Midwife in Maternity Care stated that the scope of maternity care goes beyond the care of the pregnant woman, her safe delivery, her postnatal care and the care of her newly born child. It starts earlier in measures aimed to promote the health of young prospective parents and to help them to develop the right approach to family life and to the place of the family in the community. It should also include guidance in parent-craft and in problems associated with infertility and family planning. From this it can be implied that maternity care can no longer be viewed as a separate experience but as a continuing part of an individual life with a background in the home, the family and the community. It implies a close relationship of maternity health to child health; of maternal and child health to the health of the family; and of family health to family planning and the general health of the community. A programme providing family planning services to all, centred on spacing pregnancies and limiting family size, is likely to reduce infant mortality and decrease maternal morbidity and mortality resulting from repeated pregnancies. In this context, family planning constitutes an essential factor in the protection of the health of the family and an important component of the health services and particularly of maternal and child health.[8]

The ultimate goal of the health services is to distribute their resources in such a way as to put essential health care within reach of the entire population of a country. Consistent with this goal, maternal and child health must contain the possibilities of meeting the health needs of all mothers and children. This involves measures for preventing perinatal mortality, reducing the risk of morbidity and mortality of both mothers and children, spacing pregnancies and limiting family size and promoting acceptance of health practices, taking into account the complex of activities that make up the life of the community and its systems of beliefs and practices for the preservation of health.

2. Deficiencies in maternity care

Every country, no matter the stage of its social and economic development, has a concern in meeting the health needs of all its people. In practice, however, this goal is seldom realized. This is particularly true in developing countries, where many obstacles of every kind face the public health organizer wishing to develop the basic health services. While urban centres are relatively well provided for, large sectors of the rural population (approximately 80%) have been neglected and therefore are not reached with meaningful maternal and child health care. It is in rural areas where the majority of births takes place and where large numbers of women deliver without help or rely on "experienced" women for assistance in the conduct of childbirth.

3. Current limitations of centrally organized systems of maternity care

When considering systems of maternity care, it is useful to distinguish between the centrally organized system of maternity care and the locally organized system. The centrally organized system of maternity care, planned and operated within the context of the general health services, must be taken as a whole, to include both a public, generally government-sponsored sector at peripheral, intermediate and central levels, and a non-public or private sector, supported by special groups.

Some of the dominant reasons for the deficiences of the centrally organized system of maternity care (both public and non-public sectors) in attaining the goal of meeting the health needs and demands of all, or nearly all, mothers and children are:

(a) low per capita expenditure for health services. A wide gap exists between the less developed and the more developed countries;

(b) lack of or weak health infrastructure, as a result of which the majority of mothers and children in many developing countries either lack health care or receive a type of care that is not proportional to their essential health needs;

(c) shortage of health personnel at all levels of health services for creating a demand for and providing maternal and child health and family planning services;

(d) managerial deficiencies involving problems such as: "planning decisions being guided by intuition rather than by carefully developed data showing comparative costs and benefits of alternative possibilities" (p. 109 of reference 2); disproportionate distribution of human and physical resources - health personnel, services, and facilities - across a country, so hindering satisfactory population coverage; lack of a logical division of tasks and responsibilities among different categories of health personnel, which often results in wastage of professional skills;

(e) distant location of village communities from health facilities, and communication difficulties due to poor roads, or no roads at all, and shortage or lack of transport. This seldom allows health personnel to function at village level, or village people to use the health services;

(f) lack of effectiveness of the system of education of health personnel to suit the health needs and available resources of the country and provide preparation for facing health problems in a variety of situations in rural and urban settings;

(g) unwillingness of professional health personnel to accept positions in rural areas because of lack of tools and facilities to perform their job and of an inadequate social environment;

(h) reluctance of some health personnel to accept elements of local culture - traditional healers, birth attendants - as participants in programmes aimed at the promotion of health, and to regulate their training and practice;

(i) lack of effective community participation in health programmes.

Other obstacles could be listed. Some of those mentioned can be eased or corrected through conventional methods, others would prove more difficult. They are indicative of a serious need to experiment with new approaches for the provision of health care to everyone and particularly to the populations of those areas that have been neglected.

4. Current limitations of locally organized systems of maternity care

The locally organized system of health care is a response to local needs. As the network of the centrally organized system of health care has not yet reached everywhere, populations in remote rural communities and in many periurban shantytowns have learned to rely on one another for help in gratifying their respective health needs. They have built systems of folk medicine and traditional care to deal with the burden of their health problems. Included in these systems are several kinds of traditional practitioners.

The conduct of the local Traditional Birth Attendant,* and of other contributors to the system, is construed by members of the community according to a common understanding of what constitutes rational practice - rational according to the community unde. tanding of natural and supernatural phenomena.

Sometimes traditional practices work against the common good and are not adaptive as far as the community's survival is concerned. The fact that they are maladaptive, however, does not guarantee that the people will be willing to give them up readily for different practices.

It is well known that in communities where the standard of maternity care is low and a great proportion of deliveries are assisted by untrained personnel without supervision, there is often a high rate of maternal and infant morbidity and mortality. Lack of prenatal care, hazardous procedures during labour, poor nutrition and infection, all impair maternal, fetal and infant health. For example, lack of prenatal care and, thus failure to recognize unfavourable environmental conditions (malnutrition, infectious diseases, etc.) early in pregnancy, may adversely affect the health and reproductive efficiency of the mother and lead to perinatal mortality as well as low birth weight of the infant, which reduces the chances of the child's survival during the first five years of life.

* Also named indigenous midwives, empirical midwives or traditional midwives.

Eclampsia and severe degrees of pre-eclampsia are more prevalent in communities where minimal prenatal care standards have not yet been achieved.[11]

The shortage of foodstuffs, coupled with traditional ideas and taboos against certain foods, contribute to the inadequacy of the diet and to malnutrition. As reported by Read (quoting from Sharma - 1955) "rigorous diet for pregnant women, prescribed by senior women and indigenous practitioners in parts of rural Burma, consisting almost entirely of polished rice, led to increase in beriberi among the women and to acute infantile beriberi in breast-fed babies, causing many deaths." (p. 60, reference 6)

Lack of asepsis in the care of the newborn, as for example, the application of cow dung to the stump of the umbilical cord exposes the infant to umbilical tetanus, a major cause of neonatal deaths; lack of asepsis in the care of the eyes may lead to blindness. Often enough these practices that are harmful to health come about simply because the people are unaware of the cause and effect connexions between their customary conduct and their misfortunes. These misfortunes, where they occur, are usually attributed to supernatural sources.

The Traditional Birth Attendant has a potential role to play in modern maternity care programmes. However, customs that work against the common good should be one of the main points in projects aimed at the mobilization of Traditional Birth Attendants to participate in those programmes.

4.1 Possible constraints in the mobilization of Traditional Birth Attendants for participation in the maternal and child health and family planning programme

(i) Refusal or reluctance of the Traditional Birth Attendant to alter cultural habits for fear of offending deep-rooted social relationships or a religious conviction.

Cultural habits are reflected:

- in the resistance of the women to utilize health services or to seek health personnel for assistance in child birth. Several anthropological studies carried out in rural communities [1,3,4,6] explain the hesitance of women to make use of health facilities as a basic reaction closely linked with feelings of insecurity and anxiety - e.g., when they are confronted with a new and potentially dangerous situation with which they feel unable to cope; when they are surrounded by unfamiliar health personnel whose impersonal attitudes contrast strongly with those of the husband and solicitous relatives, present at home delivery; and when traditional practices and beliefs pertaining to the reproductive cycle conflict, at points considered important, with modern methods of maternity care which are alien to their way of life. The Traditional Birth Attendant, therefore, is most likely to prefer her own way of doing things and may remain unaffected by modern methods of maternity care, as she cannot easily abandon the way of life of her community;

- in resistance to certain types of programme, i.e. methods of family planning, and in indifference to health reasons put forward for the programme. Research findings in Indonesia support this statement. According to the Report of a National Workshop to Review Researches into Dukuns* activities related to Maternal and Child Health and Family Planning, "the majority of Traditional Birth Attendants, covered by the project, believed that the number of children is fixed according to God's own will and that, regardless of the number of children in a family, God will provide for them. They also expressed the view that every child is blessed with its own fortune, although it was also agreed that a small number of children in a family tends to minimize the amount of care required by them. According to the Traditional Birth Attendants, women decline to become family planning acceptors for the following reasons, among others: conviction that a large family brings happiness; preference for traditional methods; conviction that man should have a large family according to God's will" (pp. 27-28, reference 5).

* Designation given to Traditional Birth Attendants in Indonesia.

Similar or other convictions are found in rural areas of many developing countries.

In patrilineal societies, it is the man who often decides on what is considered right practice in relation to family planning. For cultural reasons it may be difficult for the Traditional Birth Attendant to approach men in the community.

(ii) Most Traditional Birth Attendants are elderly and illiterate. Because of their advanced age, changes that penetrate deeply in their emotional life and modify patterns of thought and action are difficult to achieve. They are also likely to have limited physical ability to undertake long journeys from their home to the health units and to look for and follow up acceptors in family planning programmes.

Illiteracy may constitute a problem in relation to reporting and/or recording information relevant to planning maternal and child health and family planning programmes and assessing their operational effectiveness.

(iii) As an elder, the Traditional Birth Attendant is respected and enjoys the confidence of her community. Her status in the community can make her a source of opposition to new ideas and modern practices in maternal and child health and family planning programmes, if she herself is opposed to them.

(iv) Barriers of communication exist between the Traditional Birth Attendants and health personnel, not so much because they speak different languages as because there are wide differences between the two cultures with respect to the concept of health. People in local rural communities "have no concept of health as a positive state of wellbeing ... People who are always underfed, or anaemic, do not know what it is like to feel full of healthy energy and are often not even aware of good health as a possible goal. This profoundly affects attempts to introduce preventive health measures". (p. 118 of reference 6)

Many of the factors affecting the development and operation of the centrally organized system of health care also affect the scope of the Traditional Birth Attendant's participation in maternal and child health and family planning programmes.

The tenacity of traditional customs and beliefs is possibly one of the most difficult obstacles to overcome. However, customs and beliefs are susceptible to change. As circumstances provide new channels of dealing with them, the meaning and value of established customs and beliefs also change. There have been health and community development projects which were successfully carried out with the cooperation and full participation of the local people. Changes in the conditions of life - improved water supplies, housing, and controlling certain diseases - necessarily have an effect on the meaning of traditional customs.

5. Reasons for seeking improved collaboration between Traditional Birth Attendants and centrally organized systems of maternity care

The reasons for seeking collaboration between Traditional Birth Attendants and centrally organized systems of maternity care can be inferred from the preceding sections.

The interlocking of many factors - technical, financial, cultural, shortage of health personnel and material resources, the problem of distance, etc. - makes it difficult for the populations of distant rural communities to reach, or be reached by, modern standards of maternity care. The only source of assistance to mothers and children in many distant village communities is the Traditional Birth Attendant.

Because of her age and her perceived competence due to her knowledge and skills in the conduct of childbirth accumulated through years of experience; because pregnancy restrictions and rules of conduct accepted by local communities are often antagonistic to modern maternity knowledge and practices; because for most rural women, who are not educated to understand the advantages of modern versus traditional birth practices, professional aid is a fear-producing and anxiety-ridden situation; because the services rendered by the Traditional Birth

Attendant are based on mutual help and humanitarian principles, the community may have a positive preference for the Traditional Birth Attendant. There have been, and still are, ambivalent attitudes to the role of the Traditional Birth Attendant in maternal and child health and family planning programmes and to the question of whether efforts should be made to provide her with some organized form of training.

However, from all the considerations previously stated, it appears reasonable to assume that for decades to come the Traditional Birth Attendant will continue to have a substantial influence and role to play in the health practices and life habits of rural populations, even when modern health services are made available to them. "Modern anthropological, psychological and psychiatric research has to some extent corrected earlier and often erroneous impressions about the function and reputation of traditional practitioners. They have at times been identified exclusively with magic or witchcraft, but the way is now open for a more realistic understanding of the role they serve in their societies." (p. 15 of reference 6)

6. Origin of the present project

In 1970, participants at a WHO-sponsored interregional seminar on the Role of the Midwife in Maternal and Child Health Care, held in Malaysia, considering (i) that midwifery personnel (including Traditional Birth Attendants) play a definite role in developing countries in relation to family health and (ii) that information about Traditional Birth Attendants (number, age, distribution, etc.) is not accurate enough for planning, recommended that studies should be carried out to improve the quality of data used for planning maternal and child health programmes, involving the participation of the Traditional Birth Attendant.

The UNICEF/WHO Joint Committee on Health Policy following deliberations on a report on assessment of UNICEF/WHO assisted education and training programmes carried out in 1970 recommended "that a study be made to assess the work and value of simple types of health auxiliary workers at village level (e.g. traditional midwives, village health aides, etc.)" (p. 8 of reference 9).

In 1972 the World Health Organization, on the basis of these recommendations, sponsored an international survey on Traditional Birth Attendants and prepared a report that served as a background document for a consultation on the Role of the Traditional Birth Attendant in Maternal and Child Health and Family Planning, which was held in Geneva in March 1973. The conclusions of the consultation were considered by the Technical Advisory Committee for the project, which concurred with the recommendation that guidelines be prepared which might assist countries in determining strategies regarding the possible utilization and training of Traditional Birth Attendants. Approval of this recommendation led to phase II of the project.

The Traditional Birth Attendant in maternal and child health and family planning: a guide for her training and utilization

7. Objectives

To continue the review of data on Traditional Birth Attendants; of survey and research findings; of studies of birth practices in traditional cultures; and of training programmes for Traditional Birth Attendants.

To describe the characteristics of the Traditional Birth Attendant, especially with regard to her role and position in the community, traditional birth practices and attitudes and beliefs inherent in them, as a background for understanding her response to modern methods of maternal and child health and family planning care.

To define the role the Traditional Birth Attendant may play in maternal and child health and family planning programmes and to formulate strategies for her training and utilization in these programmes, according to the type of community in which she operates.

To prepare guidelines for planning, implementing and evaluating training programmes and for supervising Traditional Birth Attendants.

To identify problems for future research.

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1. THE TRADITIONAL BIRTH ATTENDANT

1.1 Definition of a Traditional Birth Attendant

Participants at the consultation on the Role of the Traditional Birth Attendant in Maternal and Child Health and Family Planning, mentioned earlier, defined the Traditional Birth Attendant as: "A person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other Traditional Birth Attendants". She is more commonly found in rural than in urban areas.

1.2 Profile of the Traditional Birth Attendant

The Traditional Birth Attendant is usually an older woman, almost always past menopause, and who must have borne one or more children herself. She lives in the community in which she practises. She operates in a relatively restricted zone, limited to her own village and, sometimes, those immediately adjacent.

Her role includes everything connected with the conduct of childbirth and this is the sphere in which she holds most power and authority.

Many of her beliefs and practices pertaining to the reproductive cycle are dependent upon religious or mystic sanctions. They are reinforced by rituals that are performed with traditional ceremonies which are intended to maintain the balance between the absence of ill-health and a state of ill-health.

She adheres rigidly to the dietary rules of her community and assumes an important role in the transmission of ideas concerning the nature and effects of food. The Traditional Birth Attendant is often an accomplished herbalist, whose knowledge and use of herbs, roots and barks may be quite extensive. Infusions of herbs are frequently prescribed to relieve discomfort during pregnancy, to speed up delivery, as abortifacient and for treating dysmenorrhea and certain types of illness.

As stated by Burgess, "to common problems she works out solutions within a framework of values and beliefs shared with her clients. She participates in the same cycle of cultural activity and is a recognized member of the same social universe" (p. 18 of reference 3).

Typically, the Traditional Birth Attendant is illiterate and has had no formal training. She has learned her craft from a member of her family or kin group or under the tutelage of an older Traditional Birth Attendant. Probably her clientèle first come from her kinswomen and close friends. Her reputation once established within the circle of her intimates, she may be called by women outside her immediate group. As a rule she inherits as clients the daughters of the women attended by her Traditional Birth Attendant-sponsor (p. 19 of reference 3).

In most countries she has no legal recognition, is unregistered, and is, in fact, practising outside the law. At the local level, however, there appears to be no restriction or interference with her practice. Traditionally she has freedom to pursue her activities and is readily accepted by the community she serves. The services she renders are based on humanitarian principles. According to the material resources of the family, she may be paid in cash, in kind, or not at all. In some areas the Traditional Birth Attendant depends for her livelihood on other work besides birth attendance.

The Traditional Birth Attendant is more than just a useful source of physical help to the family. She is a reassuring familiar figure, who is unhurried and patient in the assistance given to her clients, who speaks in a language and concepts they can understand and accept and who learned by experience the proper approach to the village people. Because there is a family-like relationship between the Traditional Birth Attendant and those to whom she gives assistance, her influence is felt in the daily life of the family and the community.

She is known by different titles in different countries and these titles are often suggestive of her role and her status in the community.[11] In most countries of Latin America, for instance, she is the "comadrona" which means co-mother of her clients, by virtue of being the god-mother to their children. In some areas of Rhodesia she is called "ambuya" - the Shone name for grandmother. Applied to the Traditional Birth Attendant it denotes age plus long experience of family life and is used by her clients as a form of endearment. In the Philippines she is generally known as "hilot" which means "massage".

Annex I lists the titles used to designate Traditional Birth Attendants in various countries.

1.3 Current practices of the Traditional Birth Attendant

Birth practices in a particular traditional culture or sub-cultural group within a larger one, are deeply influenced by the way of living and thinking of the people who share that culture or sub-culture. Although some common elements may be found, these practices, as a rule, vary considerably among societies. Notwithstanding the fact that the practice of Traditional Birth Attendants, belonging to the same cultural group, involves a common core of beliefs and customs, variations in techniques and advice may also be found from one Traditional Birth Attendant to another, in the same area.

The analysis of numerous reports and other studies on birth practices in traditional cultures made it possible to find out and put together details of the actual practices of the Traditional Birth Attendant. (See references at the end of the Chapter).

The main aspect of the Traditional Birth Attendant's role in rural life is, as previously stated, her association with the conduct of childbirth. In some areas her services begin long before childbirth and continue throughout a stated period after childbirth.

Prenatal and postnatal care consists mainly of carrying out measures, considered appropriate to the local culture, that make for ease of pregnancy and childbirth and ensure the safety of the mother and her child.

1.3.1 Care of women before childbirth

Where prenatal care is included in the practice of the Traditional Birth Attendant, it is in general given in the form of instruction or advice on what the pregnant woman should "do or eat" or "not do or eat". "It is a kind of preventive action supported by traditional beliefs about the causes of ill-health" (p. 75 of reference 11). All actions of the pregnant woman either "do harm" or "don't do harm". As a rule, advice on what the pregnant woman "should not do or eat" outweighs prescription of what "she should do or eat".

For example, among the population of the Valley of Ica (Peru) and some areas of Mexico, the pregnant woman is not allowed to eat pork, most fish, certain fruits and vegetables as they are classified as "cold" foods and therefore cause harm.[3,8] Sometimes the choice of food imposed on the woman is so rigidly limited that it may affect adversely the health of the woman and of her unborn child. Restrictions are also found in other areas of behaviour. In areas of Indonesia, as reported by Poerwodihardjo, "the pregnant woman is not allowed to tie a knot so that the umbilical cord does not become entangled" (p. 19 of reference 10).

There are a number of rules that a pregnant woman must observe and that vary considerably from one country, or area of a country, to another.

Prenatal care may also include abdominal massage to secure a favourable presentation, so the woman will not have a difficult delivery; giving herb concoctions if the woman becomes sick or suffers from certain discomfort; recommending when, during pregnancy, sexual intercourse should be avoided; predicting the sex of the child by the weight and protrusion of the mother's belly; predicting the probably date of labour.

Ceremonies, in the form of prayers, offerings or treating the woman with native incense or a ritual purifying bath, are performed as a means of protecting the mother and her unborn child against evil influence from the supernatural world.

Ceremonies give the mother a sense of security as she herself adheres to the beliefs of the Traditional Birth Attendant.

1.3.2 Care at the time of childbirth

1.3.2.1 Care of the mother

As a rule, deliveries are in the home of her clients, where the Traditional Birth Attendant goes when notified that labour has begun, and where she remains at least until after birth has taken place. In areas of Senegal, the delivery takes place outside the house in the back yard as it is essential for the infant to be in contact with the earth, which is considered to be the source of nourishment and the burial ground after death.[9] Some of the prescribed actions which are assumed to ward off impending perils at the time of childbirth are the wearing of talismans and charms, saying prayers, etc.

Delivery of women is often done with certain traditional procedures aimed at speeding the expulsion of the baby, quick passage of the placenta and arrest of haemorrhage. These practices may range from application of heat on the abdomen of the woman, to making her run up and down steps or maintaining certain positions, external pushing on the uterus, internal version by using the hands as forceps to deliver the baby, giving of raw eggs to provide grease in the birth canal, forcible extraction of the placenta and packing of the birth canal to stop bleeding.

In some societies, it is customary to place the woman in a kneeling position, at the time of childbirth. In others, squatting, sitting or lying down are the positions which the women, by tradition, assume for their deliveries. The position at the time of childbirth is considered important because it is more in keeping with the woman's sense of modesty than modern obstetrical positions. Exposure of the lower part of the body is, in some traditional cultures, considered an immodest act.[1]

If lacerations occur, salves, herbal concoctions or some sort of powder are applied to speed the healing process.

The care of the mother may include the adjustment of a tight binder around her abdomen. The belief, in some cultures, is that if she is not well bound, the uterus may float free of its proper position. She is also forbidden to carry heavy things, so as to prevent the still weak womb from sinking.[5]

1.3.2.2 Newborn care

Immediately after the baby is born the cord is cut with an instrument which may vary from one area, or Traditional Birth Attendant, to another and which may be used for many other purposes: bark of a bamboo or a hard and sharp stalk of a plant, razor blade, two sharp stones between which the cord is crushed, scissors, etc. Hygienic precautionary measures are not always observed. Traditionally, one of the following materials may be applied to the stump of the umbilical cord: sago flour, scraping from a coconut shell, cow dung, ashes from the heart of the stove, etc.

Variations are also found in procedures governing the length of the stump, which is usually greater than is customary in normal hospital practices and the handling and disposal of the placenta, commonly buried or burnt at the place of delivery, inside or outside the house. These procedures, in some cultures, have a deep emotional significance. The placenta is considered to have a magical strength which will protect the infant during its whole life.

1.3.3 Care after childbirth

A deep-rooted practice in many cultures is to keep the woman and the baby in seclusion or semi-seclusion, at the place of birth, for a period after childbirth which may vary from ten to forty days. The seclusion or semi-seclusion period may be accompanied by prohibitions about who is permitted to come in to see the mother and the baby, about cooking and about eating certain kinds of food.

The Traditional Birth Attendant recognizes the need for the mother to rest, to care for her baby, to breast feed the child, and, in the case of a first born, to learn how to handle and feed it. She may also advise on how to promote lactation.

In many societies, the reason for this period of seclusion lies in the fear of contamination from the woman who has given birth. The end of the period may be preceded by a ritual bath, with specially prepared water to which herbs have been added and a thorough cleaning of the house and everything that was in it, at the time of birth, to counteract the danger from contact with the birth discharge.[3,7,8,11]

1.3.4 Interconceptional care

The work of the Traditional Birth Attendant may also include preventing pregnancy by external manipulation to retrovert the position of the uterus, giving herb potions or other kinds of traditional medicine, or advising prolonged breast feeding for the same purpose. She may prescribe for infertility. She may also perform abortion and techniques for the prevention of conception. One of these techniques is application of cold to the genital area. Cold application is considered as a way of devitalizing the uterus.[3]

1.3.5 Influence of the Traditional Birth Attendant in the welfare of the rural community

The influence of the Traditional Birth Attendant is, as noted before, also felt in other aspects of the rural community life. She may also advise families on their health problems and difficulties; be consulted on how to cure various diseases; look after children when they are ill, especially in their early years; conduct rituals when girls have their menarche; advise prospective brides on their future role; perform blessings and rituals at marriage; circumcise the female child; help the family with cooking and other domestic work; and participate in committees and meetings. She may be consulted about almost anything experienced in the course of village life.

In conclusion, it may be said that the traditional system of midwifery care includes steps that are recognized in modern midwifery practices. Many of the recommendations of the Traditional Birth Attendant on the care of the woman and child during the maternity cycle make sense by modern standards. Differences between the two systems lie in the fact that most of the traditional birth practices are interwoven with traditional ideas and prejudices, which permits sometimes the cropping up of certain elements of the local culture which manifestly are harmful. Differences are also found in the lack of hygienic precautionary measures in the care of women during childbirth and of the newly-born child.

Some reported practices of the Traditional Birth Attendant have been described in detail to illustrate the importance of obtaining information on Traditional Birth Attendants' practices, in each local situation, when planning and conducting training programmes for this type of personnel.

1.4 Procedures for induction of a Traditional Birth Attendant into the locally organized system of maternity care

Variations in procedures for induction of a Traditional Birth Attendant into the locally organized system of maternity care may be found among societies depending on the characteristics of the social organization, on the differences in kinship grouping between patrilineal and matrilineal families and the responsibilities assumed by the various kinship groups. The patrilineal or matrilineal principles of organization usually determine whether the assistance to a woman in childbirth should be given by a member of the patrilineage of her husband or of her own kinship group.

Although there appears to be no absolute and rigid criteria in relation to the induction of a Traditional Birth Attendant into the locally organized system of maternity care, some factors that usually influence or encourage a person to become a Traditional Birth Attendant can be identified as follows:

In many village communities the "profession" is inherited. As soon as a Traditional Birth Attendant is considered too old to conduct childbirth, she transmits her knowledge to a member of her small circle of immediate relatives or extended family or kin group whom she initiates in the techniques of childbirth and in the mystic or religious rituals and ceremonies associated with the conduct of childbirth. The Traditional Birth Attendant-to-be, in her apprenticeship role, is allowed to assist her predecessor, is given advice on what rituals should be performed, what medicinal herbs should be prepared and what the woman in childbirth should do or not do.

In certain areas of India, as remarked by Bhandari & Bhandari, Traditional Birth Attendants commonly termed as "dais" keep the knowledge to themselves and share this only with those family members who are in their confidence. In this way, the "profession" is transferred from one generation to the other within the same family circle.[2] However, as stated in the report on the study of dukuns in Central Java, it does not automatically follow that one whose grandmother or mother was a Traditional Birth Attendant, becomes also herself a Traditional Birth Attendant. This is determined by whether the person has a talent in that field, that is when she displays characteristics of liking to help people, especially when they are ill, and not being reluctant to help although her hands are smeared with the blood of a woman giving birth.[5]

Another requirement is having herself experienced childbirth. The future Traditional Birth Attendant must have experienced the "pain" of childbirth in order to be able to assist others in a judicious and sympathetic way. For this reason, a woman who has not herself borne children never achieves complete acceptance by the community of mothers. This is particularly true in areas where traditional structures are characterized by a rigid hierarchy. It is by her experience in motherhood that the Traditional Birth Attendant in most developing French-speaking countries is designated by the name of "matrone" which derives from the Latin word "mater" or "mother".[9]

Age is another condition. Age is generally connected with wisdom, which comes from years of life experience. In certain rural areas a Traditional Birth Attendant who is still in the child-bearing age is regarded as a novice or apprentice in midwifery who will either "make the grade" by virtue of her age, experience and assumed competence or will remain an apprentice by personal choice or group evaluation.[3] Competence is judged by the success of her previous experience, under the tutelage of an older Traditional Birth Attendant.

Status in the community is also considered an asset. It is necessary that she enjoys prestige in the village. In some areas it is not rare that the wife or the mother of the village chief is at the same time the Traditional Birth Attendant for the community.[9]

Attempts to involve Traditional Birth Attendants in maternal and child health and family planning programmes should be done with knowledge of the various factors that influence the choice of a Traditional Birth Attendant. This knowledge will enable health workers to foresee the ones who are likely to be chosen as future Traditional Birth Attendants and to direct action towards gaining the local cooperation and the voluntary participation of potential Traditional Birth Attendants in organized training programmes so that they will start their practice with modern methods of maternal and child health care and family planning.

1.5 The potential role and functions of the Traditional Birth Attendant

The role and functions the Traditional Birth Attendant may be expected to play in maternal and child health services should be carefully attuned to local circumstances, resources of the centrally organized system of maternity care (financial, material and health personnel), the

extent of coverage of population by health services and their acceptance by the local population, availability, willingness and ability of health personnel to cope with the task entrusted to them of training and supervising Traditional Birth Attendants, and the characteristics of individual Traditional Birth Attendants.

In situations where the resources of the centrally organized health care system are adequate in all these aspects, the role and functions of the trained Traditional Birth Attendant, may encompass the safe management of apparently normal women during the whole maternity cycle, including infant care and participating in family planning services.

In situations where the resources of the centrally organized system of health care are limited, the functions of the Traditional Birth Attendant should necessarily be less inclusive and contingent on the possibility of providing her with training and regular qualified supervision. This point will be further elaborated in Chapter 5.

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2. SURVEY OF THE ROLE OF THE TRADITIONAL BIRTH ATTENDANT IN MATERNAL AND CHILD HEALTH AND FAMILY PLANNING

Taking cognizance of the recommendations mentioned earlier relating to the need for factual information on which to base plans for extending maternal and child health and family planning services as far as possible to the peripheral areas of developing countries and the possibility of involving Traditional Birth Attendants in such programmes, the World Health Organization initiated a survey of Traditional Birth Attendants on a worldwide basis in March 1972. The initial review of the survey returns was completed in March 1973.

2.1 Objectives of the survey

2.1.1 To collect information, and review research findings, other studies and reports on Traditional Birth Attendants and their involvement in maternal and child health and family planning programmes.

2.1.2 To develop a profile of the Traditional Birth Attendant and put together details of actual traditional birth practices and the attitudes and beliefs inherent in them.

2.1.3 To study training programmes for Traditional Birth Attendants and to determine for what functions they are being prepared.

2.1.4 To investigate government plans for health service coverage to replace or supplement the activities of the Traditional Birth Attendant.

2.1.5 To synthesize the information obtained in a report that would serve as background data for a Consultation on the Role of the Traditional Birth Attendant in Maternal and Child Health Care and Family Planning.

2.2 Methodology

2.2.1 Review of literature.

2.2.2 Data-gathering on Traditional Birth Attendants in developing countries, through the cooperation of WHO Regional Offices and selected national health authorities. The information requested covered the following points:

- legal status of the Traditional Birth Attendant;
- restrictions and freedom to practise;
- registration projects, including certification and/or licensing;
- service programmes for Traditional Birth Attendants;
- training programmes and supervision;
- incentive systems;
- research studies, surveys and reports on the utilization and effectiveness of Traditional Birth Attendants;
- plans of the government for health service coverage to replace or supplement the activities of the Traditional Birth Attendant.

2.2.3 Visits of the consultant selected for the development of this project to selected countries for on-the-spot observation of training and service programmes for Traditional Birth Attendants.

2.3 Findings

Some of the findings are summarized as follows:

2.3.1 Assistance in deliveries by village people in rural areas of developing countries in 1972. Number of countries that provided information: 45.

Assistance provided	Countries	
	Number	%
Traditional Birth Attendant who may or may not be a member of the family	39	86.7
Young village women, mostly literate who have received formal training before practising	6	13.3
Total	45	100.0

Review of available statistical data (see Annex II) disclosed that not inconsiderable obstetric services are available in the developing world, but they are largely limited to the cities and closely surrounding areas. The percentage of estimated deliveries attended by Traditional Birth Attendants in several developing countries varied from 60 to over 80% in 1972. In Burundi, as reported, out of 143 500 estimated number of live births, 123 238, or 85.3%, were assisted by Traditional Birth Attendants in 1971. (Survey of Traditional Birth Attendants in some countries of the African Region, carried out by the WHO Regional Office in 1972 - unpublished.) The number of reported deliveries in 38 rural areas of the Philippines attended by Traditional Birth Attendants in the years 1970-1972 was 15 662, or 33.12%, out of 47 287 deliveries as reported by different types of health units in those areas. In most developing countries the number of deliveries by Traditional Birth Attendants is reported as being unknown.

2.3.2 Social status of the Traditional Birth Attendants as viewed by local authorities of different countries in 1972. Number of replies: 21.

	Countries	
	Number	%
No special status, or low status	5	23.8
Influential in village communities	13	61.9
Conflicting views*	3	14.3
Total	21	100.0

2.3.3 Legal status, identification or registration of the Traditional Birth Attendants in developing countries in 1972. Number of replies: 64.

* Hospital personnel, medical practitioners, educated urbanites give her a low status. Within her community, the Traditional Birth Attendant is respected. Low social status is mainly reported by societies structured on the basis of a rigid social class system.

	Countries	
	Number	%
Legal recognition or some form of registration in selected health units	26	40.6
No legal recognition or registration	38	59.4
Total	64	100.0

Although in 38 countries, or 59.4%, the Traditional Birth Attendant has no legal permission to practise, it was reported that because of lack of control of her practice, she has freedom to perform childbirth in the community where she lives.

2.3.4 Designation of the Traditional Birth Attendants in several developing countries (see Annex I).

2.3.5 Actual practices of the Traditional Birth Attendants. Details of her reported actual practices were put together and incorporated in Chapter 1 of this document.

2.3.6 Orientation and training programmes for the Traditional Birth Attendant in 1972. Number of countries that replied to this item: 64

	Countries	
	Number	%
Existing training programmes	24	37.5
No training programme available	40	62.5
Total	64	100.0

Although training programmes vary among countries as to length, selection of candidates, etc., some similarities show through:

Objectives

The overall objective of the programme, as stated or implied through the description of the courses' content, is the reduction of maternal and newborn morbidity and mortality.

Selection of candidates

Admission requirements specify that candidates for the course should be a village member (often nominated by the village chief) and engaged in active midwifery practice.

There is a considerable variation in practice in relation to the chronological age limits among countries. Of the 24 countries conducting training programmes for Traditional Birth Attendants, 16 have established a chronological age varying from 40 to 60 years. In the other eight countries, the age limit varies from 18 to 60 years, preference being given to candidates who at least know how to read and write. It may be assumed that in these eight countries there appears to be a trend of selecting younger village women for formal training courses.

Teaching staff

Doctors, nurses, nurse-midwives and midwives are, in general, sources for teachers.

Length of the course

Variation exists as to the length of the training programmes - from three to six months. Some of the countries stated the length of the programmes in terms of the number of lessons, which vary from 12 lessons in two countries to 106 to 205 in one country.

Development of the programme

Teaching is given in the local indigenous language to small groups of six to eight trainees at one time. Techniques are simple and where Traditional Birth Attendants are illiterate, they are taught by practical methods of demonstration, repetition and experience. Teaching tools are ordinary household items which Traditional Birth Attendants always find around them.

Practical experience under supervision is carried out in hospitals and at home or in health and maternal child health centres and at home.

The courses' content, as a rule, covers the whole maternity cycle - the care of the pregnant woman, her safe delivery, her postnatal care and the care of her newly born infant.

The major aspects of the programme, identified on the basis of the number of times the same subject is repeated in different programmes, refer to the main preventable causes of sickness and deaths among mothers and the newborn:

(a) Infection of the mother and the newborn;

(b) Unrecognized complications of pregnancy;

(c) Accidents arising from ill-advised information;

and means of preventing them:

(a) Asepsis;

(b) Timely recognition of abnormalities;

(c) Abstention from dangerous manoeuvres;

(d) Proper care of the newborn.

Nutrition is also an important aspect of these programmes. There is, in general, a lack of emphasis in family planning. Only six programmes make reference to this subject.

Stipends are usually given to Traditional Birth Attendants attending the course. On its successful completion the 24 countries conducting training programmes mentioned the grant of a certificate which identifies them as "Trained Traditional Birth Attendants", equivalent to a permission to practise, although they are often not accorded legal status. In 16 countries she is also awarded a midwifery kit.

Evaluation

Programme evaluation is only mentioned by two countries, but the results of the evaluation were not reported.

It is, therefore, not known whether or not the existing training programmes for Traditional Birth Attendants have made any impact in obtaining behavioural changes - in values, attitudes and habits - concerning various aspects of maternity care. (For more details on training programmes for Traditional Birth Attendants, refer to Annex III.)

2.3.7 Utilization of Traditional Birth Attendants in family planning programmes:

In India, Indonesia and Pakistan (up to the time the programme was discontinued), Traditional Birth Attendants have been used on a widespread basis. In Malaysia, the Philippines and Thailand, family planning programmes utilizing the assistance of the Traditional Birth Attendant are being developed on an experimental basis. From information received from several other countries in Asia, Africa and Latin America, a trend towards the expansion of Traditional Birth Attendants' programmes is noticeable.

The rationale for engaging Traditional Birth Attendants in a family planning programme, as remarked in several of the research projects, is that they have contact with a large number of women and that when these women are highly motivated to adopt family planning, Traditional Birth Attendants (when appropriately trained) can be used to promote maternal and child health and family planning in rural communities.

Results of these studies indicated:

In principle, family planning, in the modern medical sense, did not face visible opposition, since family planning has traditionally been known and practised in society also with the assistance of the Traditional Birth Attendant.[2,4,7]

While some research projects indicated that Traditional Birth Attendants appear to play a role of significant influence among members of the community they serve and may become good motivators, studies carried out in rural areas of East Pakistan and West Pakistan concluded that Traditional Birth Attendants are of low status and may not be acceptable as family planning workers, despite their own feelings that they would be accepted. The results of the study in East Pakistan suggested that there are Traditional Birth Attendants who can be utilized in family planning programmes, but considering the relatively few deliveries each performs, it would seem that other persons who can reach the women near the time of birth should be sought.[1,8]

Figures for referrals of potential acceptors by Traditional Birth Attendants in Indonesia, Pakistan, Malaysia and some areas of the Philippines are so far not encouraging. The projects were very successful in the beginning, but the number of acceptors has gradually decreased. In Malaysia, as reported by Peng, observations of individual Traditional Birth Attendant's performance records shows that each individual performance differs in range, from one acceptor recruitment every two to three months in some states, to more than six acceptor recruitments per month in others. The average number of new client recruitment starting family planning appears not to be high.[5]

The main obstacle in recruiting acceptors, as reported by these studies, is religious and traditional beliefs which are fundamental to the Traditional Birth Attendant and the community way of life; distance of village from clinics; advanced age of most Traditional Birth Attendants and lack of, or insufficient, supervision.

The potential of the Traditional Birth Attendant has not been fully recognized, because field studies are recent and too few to provide conclusive evidence for realistically planning their involvement in family planning programmes. The national workshop to review researches into Dukun activities related to maternal and child health and family planning strongly recommended that, considering her position in rural communities, "efforts be made to secure at least the passive endorsement of the programme by the Traditional Birth Attendants, even if their active cooperation cannot be obtained" (p. 49 of reference 6).

2.3.8 Service programmes:

In general in the developing countries covered by this survey, there is no organized structure in which Traditional Birth Attendants function. Of the 33 countries replying to this question, in 26 (or 78.8%) there was no formal liaison between the Traditional Birth Attendants and the health services, although in many village communities they still do the bulk of deliveries. Liaison of the Traditional Birth Attendant with health units was mentioned by seven countries, most of them Latin American countries.

2.3.9 Supervision of the Traditional Birth Attendants:

Number of countries that replied to this item: 49. Some form of supervision of the Traditional Birth Attendant was mentioned by 21 countries (or 42.9%). It is usually done by the staff of the health centre, mainly nurses and midwives.

However, most of these countries emphasize that supervision is sketchy due to the lack of human resources and transportation. In most instances the only contact of the supervisor with the Traditional Birth Attendant is mentioned as being through the inspection of the midwifery kit, when the Traditional Birth Attendant comes to the health unit for replenishment of its content. Therefore, although 42.9% of the countries mentioned provision of supervision, it may be concluded that the supervision of the Traditional Birth Attendant is practically non-existent in the great majority of the countries.

2.3.10 Incentives given to Traditional Birth Attendants to encourage their participation in maternal and child health care and family planning:

The number of countries replying to this item was 47, of which 20 (42.6%) award some form of incentives to Traditional Birth Attendants. Incentives or rewards of various types were cited as a means of achieving the cooperation of Traditional Birth Attendants and maintaining their interest and the level of practice for which they have been trained. The incentives mentioned were:

(a) modest salary;

(b) cash incentive payments;

(c) simple kit such as UNICEF kit, with replenishment of expendable supply;

(d) certificate of attendance at training courses which gives the Traditional Birth Attendant formal recognition and prestige;

(e) uniform and daily stipend during training courses;

(f) payment of costs, transportation, housing and food.

Of these, the form of incentives most frequently mentioned was the award of a delivery kit. It was said that ownership of a delivery kit is often a source of pride, indicating that one important reward may be a sense of improved status in the community.

Cash incentive payments have been mainly connected with family planning programmes to encourage Traditional Birth Attendants to get more acceptors and as compensation for loss of income by a decrease in births.

No mention was made of the impact of these incentives on the performance of the Traditional Birth Attendant.

2.3.11 Governments' plans for health service coverage:

Considering that health services in most developing countries are inadequate to cover the entire population with health care, the last item of the questionnaire was related to governments' plans to extend maternity care to areas of the country lacking in, or insufficiently covered by, health services. Total number of countries that replied: 37. Plans mentioned include:

Types of planned programmes	Number of countries
1. Intensification of nursing, midwifery education at professional level	10
2. Intensification of nursing, midwifery education at both professional and auxiliary level	4
3. Intensification of training for all categories of nursing, midwifery personnel, including the Traditional Birth Attendant	6
4. Preparation of multipurpose auxiliary nursing-midwifery personnel	2
5. Preparation of auxiliary personnel and expansion of training programmes for Traditional Birth Attendants	2
6. Expansion of training of Traditional Birth Attendants	6
7. No plans as yet formulated	7

The analysis of the replies indicates that most of the governments are mainly concerned with preparation of nurses and midwives at professional level to increase coverage without losing sight of the need for the intensification or continuation of training of auxiliary personnel and the Traditional Birth Attendant.

This survey, as mentioned previously, was used as a background document for the consultation on the Role of the Tradtional Birth Attendant in Maternal and Child Health and Family Planning.

One of the conclusions of the participants of the consultation was that there is a need to develop strategies in particular communities for the training and utilization of Traditional Birth Attendants. Other conclusions are incorporated throughout this document.

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3. FORMULATION OF STRATEGIES FOR THE INVOLVEMENT OF THE TRADITIONAL BIRTH ATTENDANT IN MATERNAL AND CHILD HEALTH AND FAMILY PLANNING PROGRAMMES

3.1 A typology of situations

The specific ways in which the Traditional Birth Attendant might be influenced to advance maternal and child health and family planning depend on the degree to which a centrally organized system of maternity care prevails over the locally organized system. The range of variation actually found in the world may be summarized by descriptions of three situational types to be identified below. The general situation in any particular country will be broadly represented by one of these types. Often situations represented by all three types will exist in parts of the same country.

Classification of situational types

Type A - Isolated rural communities:

The physical isolation of this type of rural community from main roads and the limited resources of the centrally organized system of maternity care virtually preclude any contact with the local system. It is therefore difficult to reach the Traditional Birth Attendant directly.

The development of strategies in communities of this type depends on the extent to which a breakthrough of the barriers to communication and mobility takes place. Unless the isolation of an area is overcome, some pessimism seems in order with regard to the possibility of influencing the Traditional Birth Attendant. It may be possible to persuade local authorities to institute some improvements, such as opening a road and providing some sort of transport (bicycles, jeeps, or minibuses etc.) or providing water transport for the village. Once access to the area is available, arrangements could be made for a health worker from the nearest rural health facility, or a mobile team to make regular visits to the isolated villages to establish contact with the traditional health care system and to provide some simple instructions to the Traditional Birth Attendant for the improvement of her practice.

Type B - Rural communities with access routes to nearby health units:

In this second type, the resources are sufficient to allow a fair degree of contact and coordination between the centrally and locally organized systems of maternity care. Primary health care services, including maternal and child health, are usually provided by health workers working alone or from peripheral health units or subcentres. This type of rural community offers more opportunities for reaching Traditional Birth Attendants directly to organize training and supervisory programmes and to extend their role into such activities as family planning.

Type C - Communities near urban centres, where the centrally organized system of maternity care prevails over the local system:

When Traditional Birth Attendants are used, their activities are specified and supervised by health professionals who are now directly responsible for health care in the community.

In this type of community, greater opportunities are offered for the mobilization and training of the Traditional Birth Attendant for advancing maternal and child health and family planning programmes.

In order to meet the goal of reducing maternal and infant mortality by extending maternal and child health care coverage to include the Traditional Birth Attendant, strategies should be designed to meet the exigencies of each situation and translated into appropriate action programmes.

The suggested guide for the development of a strategy for collaboration between health services, TBAs and communities which follows, is mainly directed to rural communities, classified as types B and C, which offer opportunities for closer collaboration between the two

systems of health care. They may be also applicable, with limitations, to type A communities once access to these communities on a planned basis is possible. In other words the typology of the situations will change with development.

In countries where programmes for the training and utilization of Traditional Birth Attendants are already well developed, the guide may merely serve to suggest a few ways in which collaboration between health service, Traditional Birth Attendant and community might be further improved. In other countries, where collaboration has yet to begin, the guide may serve as an inventory of factors to be taken into account.

3.2 Guide to the Development of a Strategy for Collaboration between Health Services, Traditional Birth Attendants and Communities*

1. Situation Analysis

Purpose: To determine whether a change of policy is desirable and feasible by investigating relevant elements of prevailing systems - centrally and locally organized, for the provision of maternal and child health and family planning services.

Elements involved			
Functions	Structure	Constraints	Proposed tactics
At central level			
1. To define health service policy with respect to MCH care and FP services.	(i) Meetings with ministers and senior officials (ii) Meetings with leaders of medical and other relevant organizations		
2. To determine the current contribution, qualitative and quantitative, of the health services to maternal and child care and family planning services.	(i) Estimates of proportion of total births delivered by or under supervision of health personnel (ii) Estimates of present levels and cause of maternal and child mortality and morbidity (iii) Estimates of proportion of eligible couples using family planning services (iv) Trends and projections of the above		

* Based on results of the WHO sponsored interregional meeting on The Training and Utilization of the Traditional Birth Attendant in maternal and child health and family planning, held in the Philippines, 2-6 December, 1974.

Elements involved			
Functions	Structure	Constraints	Proposed tactics
At local level			
3. To determine the practices of the traditional birth attendant, (trained and untrained) and beliefs and attitudes inherent in her practices.	(i) Informal interviews with traditional birth attendants and clients (ii) Observation of TBA's practices supplemented by data collected from clients (iii)Questionnaire surveys	1. Communication - preconceived ideas of interviewer - inability to communicate to the level of TBA, including language barrier 2. Attitudes - TBA - defensive - Interviewer - critical 3. Lack of financial and logistical support for the study 4. Non-acceptance and resistance of the community to the interviewer	Utilize local residents or experienced health personnel of same sex for the interviewees Encourage the co-operation of community leaders with interviewers.
4. To determine the current contribution, qualitative and quantitative, of the TBA to maternal and child care and family planning services.	(i) Estimates of proportion of total births delivered by TBAs (ii) Surveys of TBAs and their clients to investigate the positive and negative effects of the TBA's practice on maternal and child care and use of family planning services. The aim should be to arrive at an informed judgement	Impossibility, in most areas, to isolate from all other factors the precise effect of the TBA's practice	
5. To establish the number and characteristics of TBAs (trained and untrained)	(iii)Counts by rural health units (iv) Counts by community leaders		

2. Appraisal of Alternative Strategies

Purpose: To select a strategy that will make optimum use of available resources.

Elements involved			
Functions	Structure	Constraints	Proposed tactics
At central level			
1. To assess the feasibility and comparative advantages of dispensing with TBAs or of collaborating with them in various ways.	(i) Studies of the experience of other countries		Health or other professionals knowledgeable in social sciences, may be used to help identify relevant and irrelevant foreign experiences
	(ii) Interdisciplinary and interprofessionals' meetings and discussions	Preconceptions and vested interests of different disciplines and professions may interfere with fruitful discussions	Meetings should be carefully structured and managed by problem-oriented investigators
	(iii) Small-scale experiment and case studies	Shortage of personnel qualified to produce reliable findings	Other existing institutions in the country - university, public health or health sciences institutes, etc. - may be asked to help by providing specialists or training courses in the required techniques
	(iv) Projection of the consequences for health care of mothers and children and resources of adopting different strategies	Lack of personnel qualified in the required techniques (research, programme formulation, etc.)	International or outside assistance may be requested
	(v) Consultation with government departments and professional bodies. Some strategies may be attractive in principl , but impossible in practice owing to	shortage of resources; opposition of authorities or professional bodies	The strategy for which in the opinion of the government and professional bodies, constraints can be removed should now be translated into action

3. Implementation of Strategy

Purpose: To secure specified changes in existing arrangements for collaboration between health service, TBA and community

Elements involved			
Functions	Structure	Constraints	Proposed tactics
Central level in collaboration with intermediate and local levels			
1. To define operational goals	(i) Establishment of national and local targets and timetables for the: - training and deployment of TBAs; - training of teaching-supervisory staff; (ii) Establishment of resource needs and timetable for the provision of facilities and supplies		
2. To secure regulations or necessary changes in existing legislation and administrative arrangements for the training and collaboration of the TBA in maternal and child care and family planning services.	(i) Coordination of effort between ministries and agencies interested in the welfare of rural communities and economically depressed groups to secure: - support to the programme of training and utilization of the service of the TBA - formulation of policies, accordingly; - integration of the TBA's contribution with the total system of health care (ii) Coordination at village level, between the activities of workers from different agencies		
At local level			
3. To identify practising TBAs, trained and untrained.	(i) Enumeration by local health units in collaboration with community leaders (ii) Preparation of record forms containing essential information (age, sex, status in the community, etc.) to be kept in the health services		

Elements involved			
Functions	Structure	Constraints	Proposed tactics
4. To establish criteria and methods for the selection of TBAs suitable for training.	(i) Development of criteria for selection of TBAs		Refer to suggestions for selection of trainees in 5.1.5
	(ii) Consultations with - community leaders; - TBAs; - experienced health workers		
5. To specify required changes in beliefs, values, skills, and practices of the TBA.	(i) Assessment of priorities among needs for improved health care of mothers and children		
	(ii) Identification of those current practices that are beneficial to the physical and emotional wellbeing of the TBAs clients		Encourage beneficial practices, harmless ones need or should not be changed. Try to nullify harmful practices by wise and prudent exploitation of others which are beneficial or, at least, harmless (Refer to 5.1.1)
	(iii)Consultation with TBA on scope of training	Reluctance of TBAs to accept training largely owing to her awareness of what is acceptable to her clients	Ensure support of local community leaders by: - relating the training programme to existing community health problems; - making them active partners in all phases of the training programme
		Community indifference or opposition to modern ideas about family planning	Present family planning as a means of spacing births rather than of limiting family size
			Health education directed to the TBA community
	(iv) Consultations with health workers on scope of training	Pessimism about TBAs' contribution	Education of the health personnel

Elements involved			
Functions	Structure	Constraints	Proposed tactics
	(v) Consideration of limitations imposed by TBA's age, low educational level, other work, etc.		Expanded role too broad for TBA and might be contracted
	(vi) A study of relevant legislation and policies governing the practices of TBAs and the extent to which they are actually enforced	Legal constraints	At central level: Initiate action for liberalization of unnecessary restrictive measures; Enact measures to govern the TBA's practice within certain bounds; In general, expectations should be realistically modest
	(vii) Definition of the tasks expected of a trained TBA, taking into account the results of (i) to (vi) above. The definition should specify minimum expectations and a range of desirable extensions, applications of which to depend on the capacity of individual TBA and circumstances under which she works (refer to 5.1.4 and also to Annex V)		
6. To teach the TBA modern methods while reinforcing those traditional beliefs, values and practices believed to contribute positively to maternal and child care.	(i) Community-based training for the TBA; supervised practice	Old age of the TBA. Limited formal education	Teaching should be simple and grounded in a knowledge of the beliefs, values, practices and working circumstances of the TBA. Modern methods should, as far as possible, be adjusted to traditional ones rather than vice versa (refer to Chapter 5)
	(ii) Use of trained TBAs as instructors (this would be an important way of bridging the gulf between modern and traditional ideas).		
	(ii) Refresher courses, as necessary		
	(iii) Production of simple pictorial manual and teaching aids attuned to local culture	Lack of competent personnel to prepare a manual with suitable contents for practice	In the preparation of manual and teaching aids, utilize personnel with knowledge, understanding and experience of the realities of work in rural and/or economically depressed communities

Elements involved			
Functions	Structure	Constraints	Proposed tactics
		Lack of suitable teaching aids for trainers and trainees	Involve the TBAs themselves in the preparation of both
	(iv) Recognition in training timetables of the demands made on TBA's time by seasonal, religious and occupation circumstances		Arrange schedule according to the convenience of TBAs
At all levels of health services			
7. To consider ways and means of supporting the status of the TBA in the community and of ensuring the use of safe methods of maternal and child care and spacing births.	(i) Institution of a system of rewards for TBAs that would motivate their acceptance of necessary changes in their practice	Because of the overlapping of roles of midwives and TBAs, midwives may resist such practices, regarding them as likely to diminish their professional status	Regulations defining boundaries of the TBA and health workers' operations may be helpful It is important to ensure that measures adopted in relation to rewards will not have the effect of alienating the TBA from her community
	(ii) Enlistment of the support of community leaders (formal and informal) and of the community at large for necessary changes from traditional practices		Use of all available means to educate and inform the community so as to reduce the reluctance to change traditional practices (refer to Chapter 4)
	(iii) Financial allocations for implementation of training courses		
8. To teach health professionals to understand the traditional beliefs, values and practices of the TBAs, their positive and negative contributions to health care, and techniques required for the accomplishment of (5) and (6) above.	(i) Community-based training for the prospective trainer-supervisor of TBAs (refer to Chapter 6)		
	(ii) Refresher courses according to need		
	(iii) Production of technical manuals for use of trainer-supervisors		
	(iv) Development of materials and techniques to help professional health personnel understand relevant sociological and anthropological findings. The purpose is to help professionals bridge the gap between modern and traditional ways of thinking		Create courses for the training of health personnel, preferably in rural areas

Elements involved			
Functions	Structure	Constraints	Proposed tactics
	(v) Inclusion of traditional health practices in the basic educational curricula for health professionals, as well as participation in experiences that will promote understanding of the problems they will encounter when they are confronted with subcultures of rural or economically depressed communities		
9. To set up a supervisory system to sustain and improve performance	(i) Assignment of supervisors. Supervision of the TBA will usually be the responsibility of primary health workers: nurse, midwife, auxiliary health worker, etc.		
	(ii) Definition of function and responsibilities of supervisor		
	(iii) Designing a supervisory programme for the TBA		
	(iv) Establishment of a referral system and health care provisions for clients of the TBA		
	(v) Follow-up and assessment of the TBA performance, carried out in the village and at the health centre. Supervision should encompass the general functioning of the TBA in the community and all aspects of her performance as a health care worker	Long distances. Poor terrain. Inadequate transport	Group meetings, instead of individual meetings with TBAs Use of mobile or village clinic Involve the community in efforts to solve physical difficulties
	(vi) Follow up and assessment of trainer-supervisor of the TBA by competent health staff		

Elements involved			
Functions	Structure	Constraints	Proposed tactics
10. To provide adequate material resources.	(i) Provision of classrooms, hostels, facilities for practice, manual and other educational aids, transport, water supplies, etc. (ii) Allocation of funds for salaries, allowances, expenses, rewards (iii)Arrangements to ensure that supplies and equipment are appropriate to local needs (iv) Arrangements to avoid failure or delay in provision of supplies and equipment	Limitation of funds and too great dependence on external assistance (A problem with external assistance is that if it is withdrawn, projects dependent on it tend to founder)	Apply for adequate funding from national and local resources, with maximum recourse to improvization Encourage villagers themselves to finance supplies and equipment
11. To ensure judicious use of resources.	(i) Problem-oriented management and maximum delegation of responsibility to peripheral or local level (ii) Maximum information exchange within the system and relevant agencies, national and international		

4. Evaluation and Studies

Purpose: To measure system performance against specified criteria for effectiveness, efficiency and acceptability and to extend the boundaries of scientific knowledge useful to programme planning and implementation.

(Elements of strategy are included in Chapter 7: "Evaluation" and Chapter 9: "Conclusions and Problems for Future Investigation".)

A model of a matrix which expresses in a concise form basic elements of the infrastructure needed for the training and utilization of the assistance of traditional birth attendant in maternal and child health care and family planning services is included as Annex VI.

For clarification of some aspects involved in the implementation of a strategy, the following points are further elaborated.

3.3 Team work

An effective programme for Traditional Birth Attendants requires close team work among several categories of health workers and professionals with special preparation in adult education and social sciences. The size and the composition of the team may vary according to the needs of a particular situation and the limitations in the categories of available personnel. Because of different backgrounds, ideas, skills and experience, team members should possess some common characteristics: (a) all must know and understand the social structure of the rural community and the life of its people; (b) all must be willing to accept the responsibility entrusted to them and contribute; (c) each member should have a basic idea of what fellow members are doing and carry out his part in such a manner that it supports the work of all; (d) each needs a basic belief in the team approach.

Multidisciplinary team work is more than a division of responsibilities among the team members. It is a sharing of functions. Where a multidisciplinary group of workers are involved, as a team, in the training and supervision of traditional birth attendants, overlapping of services may necessarily be expected and must be accepted by all members of the team. Some activities assigned as responsibility of the nurse-midwife or midwife may at times be undertaken by other members of the team. The nurse-midwife or midwife may also assume, on occasion, responsibilities assigned as the work of a health educator, medical officer, sanitarian, auxiliary-midwife, etc., depending as stated above on the size and composition of the team and the needs of a particular situation.

3.4 Incentives or rewards

Attention should be directed toward providing some sort of incentives or rewards to the Traditional Birth Attendants who are assisting the maternal and child health and family planning programmes, to ensure their continued cooperation.

In evaluating various possible incentives, consideration should be given to cost; whether they bring about the desired behaviour; whether they may further other social goals.[3] A good starting point to decide on an incentive system that will prove effective in securing the cooperation of Traditional Birth Attendants would be to ask community leaders to choose between alternatives.

Rewards or incentive possibilities are material goods or those yielding social benefits. They may be given to the Traditional Birth Attendants or to the community.

Examples of material goods which may result in the Traditional Birth Attendant's cooperation with maternal and child health and family planning services are: providing a near-by water supply, improving housing, providing clothing, agricultural supplies to improve farm practices, recreation facilities, etc. Those which may foster social changes are: transistorized radios or television sets given to the village, which might help change attitudes including attitudes toward family planning, opening up communication for the village and providing transport facilities, education for existing children (providing schools, teachers).

These incentives may represent to the Traditional Birth Attendants a symbol of prestige and may be a valuable line of cooperation with health programmes.

A word of caution is needed concerning cash incentive payments, as they may have a negative impact in maternal and child health and family planning programmes. Disadvantages of this form of incentive are: Traditional Birth Attendants may become motivated by money, so reducing the reassuring quality of their services; the balance the people have achieved in an environment where they rely on mutual aid in cases of need may be disturbed by financial inducement; interest in money benefit may result in the disregarding of the real benefit of family planning programmes; cash incentive systems are open to criticism of bribery and could cause jealousy and distrust among Traditional Birth Attendants. Experience has demonstrated that delay in payments or stopping of the allowance have dampened the Traditional Birth Attendant's interest and have had an adverse effect on programmes.

Before a full-scale incentive programme is launched, pilot studies and field trials are essential to test ways in which the various forms of incentives really influence the Traditional Birth Attendants to cooperate with health measures. A study of various reward systems, through field experiment, so as to maximize the efforts to recruit family planning adopters, at the highest degree of cost effectiveness, is included by Rogers[5] among priority topics for future investigation of Traditional Birth Attendants and family planning.

3.5 Legislation; regulation; registration

One important question that needs to be answered by countries undertaking the training and utilization of Traditional Birth Attendants is how the centrally organized system of health care can regulate their practice. Considering that the Traditional Birth Attendant's activities are sanctioned by custom, tradition and rituals that are part of community life, the introduction of new legal restrictions and regulations may seem irrelevant to their way of doing things and may disturb the delicate balance achieved by the local population.

A review of available data from 64 countries with regard to legal status, identification and registration, and freedom to practise of the Traditional Birth Attendant shows a wide range of situations (refer to Chapter 2):

(a) Traditional Birth Attendants do not have any legal status but are free to practise in their respective communities.

(b) The practice of the Traditional Birth Attendant is controlled by a regulation of the health agency, and a register of them is kept.

(c) The Traditional Birth Attendant is not covered by any legislation. However, the health agency, through training courses, specifies their duties and responsibilities. She is provided with a certificate that identifies her as "registered and controlled by the Health Centre" and that is revalidated every six months.

(d) Registration of the Traditional Birth Attendant is purely on a local basis at maternal and child health centres, where there is control and supervision of Traditional Birth Attendants' activities.

(e) Traditional Birth Attendants are not allowed by law to practise in locations where a trained midwife is available.

(f) Traditional Birth Attendants have no right to practise under any circumstances and they may be punished by law if they do so.

In many countries, midwifery practice is governed by legislation. Most of these laws take into consideration the traditional factor wherein the principle of restricting the practice of midwifery to qualified personnel is applied, while provisions are included to allow those who have not yet received training to continue for a certain period of time to practise in areas where there is lack of qualified persons.[7]

3.5.1 Legislation - pros and cons

It is recognized that it is not only the right but the duty of the State to pass such laws or ordinances as may be necessary for the preservation of the health of the people.[6] Hence, the passage of laws for the preservation and promotion of health in general, and the protection of the health and well-being of mothers and children in particular, is essential. With regard to the control of the practice of Traditional Birth Attendants, however, education of the public must precede any legislation, so that the demand for safe delivery practices will come from the people themselves. Setting rules of conduct and action, commending what is right and prohibiting what is wrong, through legislation, requires personnel to follow closely the activities of the Traditional Birth Attendant and to see to it that she is complying with the law. Considering the various factors that come into play in regulating her practice, it is deemed that positive laws, which guide and improve her practice rather than restrict her, should be encouraged.

3.5.2 Identification and registration

Considering the limitations of the Traditional Birth Attendant and the milieu which she works, it would be difficult to apply the force of the law to regulate her practice. Her identification, through community leaders and her clientèle, keeping a record of her name, personal circumstances and activities, may suffice as a means of making her conscious that the health agency is concerned with what she is doing. The maintenance of a list of Traditional Birth Attendants at the peripheral level of the health service will also serve as a basis for training and supervision. As explained by Grad, registration is a device for record-keeping and for information purposes. Persons engaging in particular occupations may be required to "register" with a regulatory agency. This means that anyone is free to engage in the particular activity, but that having entered in it, he is under an obligation to inform the agency of that fact, to tell the agency what he is doing, who he is and where he is located, so that the agency will be able to supervise and control the activity from time to time.[2]

3.5.3 Regulation through permits

A permit is defined as an official authorization to practise or perform an act not necessarily forbidden by law, but which is not permissible without such authorization. It involves the imposition of conditions on an activity. The regulation of the activity of Traditional Birth Attendants is achieved by placing conditions on the granting of the permit. These conditions may involve training and experience, age, or any relevant factor to ensure that the applicant will carry on her task in a manner acceptable to the regulatory agency.[2]

With this background information, health administrators concerned with the programme of training and utilization of Traditional Birth Attendants will be in a better position to consider ways and means of regulating her practice. It should be borne in mind, however, that education of the public and the Traditional Birth Attendant herself must accompany or should preferably precede whatever measures are adopted to regulate her practice.

Mr J. Fenney, Field Director and Administrator of a Joint Study Group of the International Federation of Gynaecology and Obstetrics (IFGO) and International Confederation of Midwives (ICM) in a conference held in Ghana in December 1972, cited the experience of the Government of Great Britain who, in 1902, awarded a "licence to practise" to 12 300 untrained midwives. Simultaneously, a training programme for midwives was begun, but it took 45 years before the last untrained midwife ceased practising her profession.[1]

In conclusion, stringent legislation and compulsory measures to put Traditional Birth Attendants out of practice should never be applied, since, even in the presence of trained health personnel, people in rural areas, until they have reached a certain level of socio-economic development, will rely on the Traditional Birth Attendant because she is part of their cultural milieu.

It is considered necessary, especially at the peripheral level of health services, to maintain an up-to-date list of the Traditional Birth Attendants, with name, location, other personal characteristics, and previous training (date and place) duly indicated. This can be done in cooperation with the formal leaders in the locality. After training, her certificate of training may serve as a temporary permit to practise, renewable after a certain period of time, if performance is satisfactory. Agreements worked out with local community leaders and Traditional Birth Attendants themselves, setting out what ought to be done to help mothers and children attain better health, will serve as a more effective safeguard than any legislative fiat.

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4. COMMUNITY SUPPORT FOR THE PROGRAMME

In programmes aimed at changing people's cultural habits, such as programmes for training and utilization of the assistance of Traditional Birth Attendants in maternal and child health and family planning, the need for the community's cooperation is, as stated earlier, essential. If its members and the Traditional Birth Attendant refuse to accept changes in their practices in the ways deemed most advisable by the health workers, there is little the latter can do to force them to change. As a corollary, it follows that attempts to introduce some changes in the lives of people in the community should be done only with voluntary participation; the community must be an active partner in the change process. The motivation of the people and their receptivity towards the programme for Traditional Birth Attendants is of great importance for local collaboration. Failure in introducing changes in traditional birth practices may be largely ascribed to the inability of the health worker to apply his knowledge in terms of the local environment.

One of the factors which influence the adoption of the programme is its acceptance and support by the most highly respected groups in the village. There is, therefore, a need for health workers to be familiar with the social organization of the community where they will work.

All communities, be they of type A, B or C, have some form of social organization or an official administrative structure, but this organization is not identical in all societies. In many rural communities there is a chief or headman who holds administrative and judicial power. Others are governed by a council of elders or a council of family heads. In some societies, as mentioned by Goodenough, leadership is hereditary and in others the traditional systems of ranking individuals are based on educational differences, economic position or occupational distinctions. Leadership may also be achieved by magical power or other skills.[2]

There may be other organizations in the community which influence the lives of the people, such as the established religions. They are, in great part, interwoven with other traditional organizations of the community and have remained, in many instances, so powerful that if they oppose a change it has little opportunity of acceptance.

Another type of organization that may affect the acceptance of a new idea or practice is that of kinship. The importance of the kin group is stressed by Read when she states that "in societies as yet barely touched by modern medicine, the kin group decides whom it will consult and, when a traditional practitioner is being consulted, the kin group has to be present at the consultation and the treatment and assumes the responsibility for paying the practitioners. The patient relies, and is dependent on, the kin group for support and help . . ." (pp. 11-12 of reference 4).

The importance of the kin group is also evident in the resistance of rural expectant mothers to hospitalization because it means separation from her protective group.

Other agencies in the community which may act to accelerate or hinder changes in health practices include women's organizations, community development groups, etc.

The report on the study of Dukuns in Central Java mentioned that people in the community are subject to the influence of the following groups:

(a) The pamongdesas or leaders in the Government

(b) The employees/officials of the health services, who at certain times visit the villages or can be met in the clinics, such as the doctors, midwives, nurses, etc.

(c) School teachers

(d) Religious leaders

(e) Leaders of mass media and political organizations.

(f) The traditional practitioners (Dukuns) including the Traditional Birth Attendant (Dukun-bajis).

The ordering, as reported, was not based on the strength of their respective influence.[3]

The formal and informal cooperation of local community leaders in the programme is especially necessary. They are often better placed than health professionals to influence the behaviour of Traditional Birth Attendants and to secure acceptance by the community of changes in their customs. Conversely, they are well placed to hinder change if they wish to do so. It is therefore essential that the health worker finds out how each local system works, identify all leadership elements in any given locality and enlist their goodwill and participation in all phases of the development of the programme.

Any change is likely to meet with resistance, especially at the start. Ways of establishing rapport with community leaders, Traditional Birth Attendants and the community at large and securing their acceptance and participation in the programme, can be as varied as cultures. There is no single formula that can be used in all situations. Some guidelines for reducing resistance and winning rapport were formulated by Arensberg and Watson and are quoted below, as they may be useful for health workers in their initial contact with an alien culture.

According to Arensberg and Niehoff, the following is suggested:

"(a) Explain truthfully, but as simply as possible, your purpose in asking for an accumulating knowledge about the local culture.

(b) Enter new places for purposes of observation, only with the consent of the people involved, and if possible at their request and invitation.

(c) Respect native values, conventions, taboos and prejudices.

(d) Maintain confidences. Information given to you in confidence must not be indiscriminately disclosed.

(e) Refrain from making moral, esthetic or other judgements about the culture or persons from whom you are learning.

(f) Avoid expressing comparisons between your own culture and the local one.

(g) Work from the top down, i.e. pay the necessary deference to the scale of values the community holds." (p. 191 of reference 1.)

Some of Watson's suggestions are similar to the ones formulated by Arensberg. Watson also emphasizes the need for the support of top officials, of making community leaders feel that the project is their own, and making changes as much as possible congruent with native values and ideals. To these he adds the importance of making people realize that the change will reduce, rather than increase, their present burden and therefore will bring some practical benefit to the community; involving community groups in the project, making people secure and reducing threat.[5]

The influence of top officials depends largely on their personality and the respect with which the community regards them. There are communities where the presumed leaders are front men only and do not wield real authority. Goodenough points out that even in such cases, on making initial contact with the community, it is best to deal with the official representatives, regardless of how the members of the community regard them. At the same time, one should make an effort to find out who, if any, are the other leaders in the community and to clear one's moves with them also.[2]

There is not always social cohesion in the community. There are forms of disintegration, and the health worker may be faced with situations where the community is split into factions between rival leaders and their followers.[4] Sometimes the rivalry is so intense that it is impossible to obtain approval of one faction without antagonizing or losing approval of the other. Health workers should avoid being identified with any one faction.

For a change in practice or customs in maternity care to be accepted in some communities, it must be arrived at in accordance with procedures and rituals; without such observance, no change can be made. One of the best approaches to understand the basic values of their procedure is, according to Read, to discover the occasions on which cultural values are stressed and made articulate.[4] This discovery is made possible by taking part in local activities - religious or magic ceremonies, weddings and other community and Traditional Birth Attendants' activities. If the health worker shows genuine interest in the people, participates in local culture, learns and displays standards of behaviour which are considered proper for the individual in particular situations (for instance, common courtesies or etiquette) he will be able to build up the kind of confidence essential to his work in rural traditional communities.

In general, changes will be accepted more readily by the young than by the older people. Identifying and training younger successors of Traditional Birth Attendants "may be the prime moves in creating an intensified generation effect" (p. 112 of reference 1).

Another point worth mentioning is the time of introduction of a project. The health worker should become aware of the seasonal working pattern of the people of the community. In rural communities, agricultural work periods are particularly critical. As pointed out by Arensberg and Niehoff,"a peasant people who are dependent on a staple crop will be unlikely to sacrifice time for something new when their next year's supply is at stake" (p. 123 of reference 1). A project of training Traditional Birth Attendants should not be planned for periods when they are occupied in a work essential to their life, such as rice-planting seasons in some rural communities. This may explain the apparent unwillingness of Traditional Birth Attendants to participate in training programmes and inability to attend or to accompany potential acceptors of family planning to clinics. It also leads on to the great need to study the rural women's life in a village setting before any project that requires their cooperation can begin.

In summary, it may be said that a powerful determining factor in obtaining the cooperation of a local community at large, and of the Traditional Birth Attendants in particular, is the nature of the social groups which control or influence the behaviour of individuals. It is vital that the health worker understand the social groups with whom he must work to be able to design intelligent programmes for changes and foresee the new problems that change will bring. The health worker must win the acceptance and confidence of the community, institution or groups where or with whom he will work, and keep in mind that attempts to make changes in the lives of the community people should be done only with voluntary consent and participation.

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5. THE TRAINING OF THE TRADITIONAL BIRTH ATTENDANT

5.1 Introduction

5.1.1 The training of Traditional Birth Attendants is a process of changing their behaviour patterns in relation to maternity care. When training is viewed in this way, it is clear that there is a need to study the Traditional Birth Attendants' current practices and the beliefs and attitudes inherent in them and to compare these practices with standards of safe maternity care, which might possibly be achieved in the community where they operate. From this analysis, certain positive and negative elements emerge in the practice of the Traditional Birth Attendant which may be categorized as beneficial, harmless and harmful. Below are some examples of each category, using as terms of reference the description of traditional birth practices given in Chapter 1.

Among the positive or beneficial elements are the Traditional Birth Attendants' recognition of the need for the mother to care for her baby; to encourage prolonged breast feeding; to advise on how to promote lactation; to allay anxiety by creating an atmosphere of confidence and trust; to attend to the mother and her family for a longer period of time after childbirth as compared with assistance given by qualified practitioners; her prompt response and appearance in time of need, etc. Many of these practices are not out of line with modern methods of maternity care.

Some examples of harmless practices are: customs governing the length of the umbilical cord which is left attached to the navel; advice on wearing amulets, talismans, or charms; the performance of rituals and ceremonies associated with certain practices, as for example the ceremony of handling and disposal of the placenta and of the umbilical cord; the ritual bath for the woman and the cleaning up of the house and everything which is in it, at the end of the period of seclusion after childbirth, etc. Many of these practices are perceived as protective measures, and although physically harmless, they have positive psychological effects on the Traditional Birth Attendants themselves and their clients.

Among the harmful practices, shared by almost all Traditional Birth Attendants everywhere, are the severe restrictions imposed on the diet for the pregnant and lactating woman; strongly massaging the abdomen or squeezing forcefully the uterus of the pregnant woman, internal version or forcing bearing down too early to hasten delivery; the lack of asepsis in their procedures and materials during delivery and in the immediate care of the newborn; the performance of female circumcision, etc. Harmful practices are also connected with the lack of recognition of dangerous signs in a woman and her child during all stages of the maternity cycle, or when a woman is at risk, and, therefore, with their failure in initiating appropriate actions when such situations occur; (e.g., referring clients to qualified practitioners).

The delineation of beneficial, harmless and harmful practices has implications in the selection of the training objectives, in the sense that it suggests the kinds of behaviour which should be aimed at in the training programme. As stated by Kelly, the local body of beliefs and practices associated with pregnancy, childbirth and post-natal care should be the fundamental point of reference of a programme of training for Traditional Birth Attendants.[1] It seems, therefore, obvious that the training programme should be directed toward:

- the encouragement of beneficial traditional practices associated with pregnancy, childbirth and postnatal care, including the care of the newborn;

- the maintenance of harmless practices, and acceptance of those rituals and ceremonies which are equally harmless, although they may appear incongruous to a person trained on scientific lines. Rituals are particularly important. The trainer may be brought up against a peremptory refusal of the trainees to alter a ritual act which is often related to cultural beliefs about life and the supernatural;

- introducing changes in traditional practices which manifestly are harmful, possibly by relating new practices to some act with which the Traditional Birth Attendant is familiar. For example: one of the harmful practices is, as mentioned earlier, the severe food restrictions imposed by Traditional Birth Attendants in the diet of pregnant

and lactating women. These restrictions are often based on the arbitrary classifications of "hot" and "cold" foods and their effect on the health of the mother and her baby. If, in a certain community it is believed that the diet of the woman should consist of certain and limited kinds of "hot" foods, the trainer might be able to persuade Traditional Birth Attendants to recommend that other available foods also classed as "hot" should be added to the diet. The trainer is thus likely to meet less resistance from the Traditional Birth Attendant than by the suggestion that "cold" foods should be added to the diet. By capitalizing on elements of local culture, i.e. maintaining the local classification, the woman might obtain an adequate diet, without infringing the dietary rules accepted by the community and the Traditional Birth Attendant;

- introducing new practices, as for instance, pregnancy spacing.

5.1.2 It is essential that the Traditional Birth Attendant be involved thoroughly in the training programme. In other words, the Traditional Birth Attendant trainees should themselves be given the opportunity to plan the programme content according to their felt needs, beliefs, values and circumstances. Preliminary discussions on what topics they would like to be included in the programme, and exchange of experiences among the trainees at the initial stage, can be an effective means of bringing the Traditional Birth Attendants to express their needs and to accept the programme as their own.

When the interests and felt needs of the Traditional Birth Attendants are verbalized in a restricted or limited way, as compared with the need for changes identified through the direct observations of their practice and study of the community, this indicates gaps which need to be overcome if the Traditional Birth Attendants are to receive effective training. Some trained Traditional Birth Attendants who might have received previous training, who have acquired accurate skills in their practices and who have recognition in the community may be of great value in the construction of the programme content. Trained practising Traditional Birth Attendants are recognized by the trainees as people of their own kind and, therefore, discussions are likely to be developed more openly, honestly and smoothly, without any feeling of pressure or imposition from outside.

5.1.3 Other factors which should be considered when designing a training programme for TBAs are:

- the characteristics of individual TBAs: limited or lack of formal education, age, learning capacity and status in the community;
- priority needs for improved maternal and child health care in a particular area;
- adequacy of human and physical resources (services, facilities and mainly health personnel) for the training and on-the-spot supervision of the TBA.

In summing up what has been said it appears in order to quote the following statement made by Kelly:

> "It seems dubious that any programme - be it for midwifery training or anything else - can be effective if it is planned by remote control, for broadside applications. It will have better chance of success if it is designed and tailored to measure, zone by zone.
>
> "In the case of midwifery, a major point of departure should be the social position of the Traditional Birth Attendant in the local community. Furthermore, the programme should be painstakingly planned so as to interdigitate - with the minimum conflict and maximum exploitation - with local customs and practices related to pregnancy, birth, and post-natal care." (p. 8 of reference 1.)

5.1.4 The training programme, as outlined, is only meant as a guide. It is presented in the following sequence:

Unit 1 - Antepartal care;

Unit 2 - Intrapartal care;

Unit 3 - Postpartal care;

Unit 4 - Interconceptional care;

Unit 5 - Infant care;

Unit 6 - Coordination of the activities of the trained TBA with the health services and the community.

Main objectives, learning objectives and learning tasks/skills are incorporated in each unit. They suggest a way of approaching a training programme for TBAs. An attempt was made to cover the whole maternity cycle as it seems applicable to a trained TBA in communities where health resources are sufficient in quality and quantity to include the participation of this category of health personnel in the activities of the centrally organized system of maternal and child health.

It is recognized that in some countries or areas of a country it may not be possible or even advisable to cover all aspects of maternity care, as included in the suggested training programme. In some communities, limited physical and human resources as well as the characteristics of individual TBAs will only allow the inclusion in the training programme of some of the learning objectives and learning tasks associated with the conduct of safe delivery and immediate care of her newborn infant. In others, the existing resources may allow for desirable extensions including antepartal, postpartal and infant and child care. Some TBAs may also participate in pregnancy spacing, depending on the policy existing in the countries.

Desirable extensions may be accomplished over a period of time after training, through continuous guidance and supervision or step-by-step training programmes.

Practice is combined throughout the training programme and should be carried out in a place to which the TBA has cultural affinity - in a clinic and in the home of the TBA's clients. The clinic may be attached to a district health centre or it may be set up by a midwife or nurse-midwife in a village. The clinic may or may not be attended by a doctor.

The training schedule should be arranged according to the convenience of the TBAs, and should be flexible, as planned sessions may need to be interrupted due to the services of the TBA being required by her clients. Trainer-supervisors should take advantage of such occasions to accompany the TBA and guide her activities on-the-spot.

5.1.5 It is suggested that in the selection of trainees, priority should be given to those Traditional Birth Attendants in communities B and C who:

- are sponsored by the community. This could be an indication that the community accepts the need for her training;

- are influential in their communities, as their acceptance of the training programme could influence their colleagues in a positive way;

- are more active in the community;

- are willing and available to attend the course.

Selection needs also to be concerned with the good health of the Traditional Birth Attendant as could be evidenced by a physical examination, indicating freedom from infectious diseases, satisfactory eyesight, etc.

5.1.6 The number of training courses and of trainees per course depends on the number of specially trained personnel who are available for the teaching and supervision of TBAs.

5.1.7 The training should be as much as possible individualized or carried out in small groups mainly for the following reason:

- an older person has some degree of decreased learning ability and motor slowness in acquiring new skills or changing traditional patterns of behaviour. Information will need to be given slowly, at individual TBA's own pace, that is, according to the rate she can absorb the necessary information.

Please remember that the training should be flexible as to the length of time, content, sequence of its content objectives and training schedules. START SMALL AND REALISTICALLY. Select one well defined topic area which has been identified by the TBA and the trainer as a priority need for the TBA. START ANYWHERE.

The trainer-supervisor should be ready to ADD, DELETE AND IMPROVISE to suit the needs of the TBAs and the circumstances under which they work.

Remember also that the programme which follows is only a suggested guide.

5.2 Suggested Training Programme for Type B and C Communities

Decision on the selection of learning objectives was based on the survey of the activities of Traditional Birth Attendants (refer to Chapter 2) and "Suggested tasks of the trained Traditional Birth Attendants working in collaboration with the health establishment" formulated by a multidisciplinary group of participants from two WHO sponsored follow-up interregional meetings:

- Interregional Seminar on the Training and Utilization of TBAs in maternal and child health and family planning, held in El Salvador, Salvador, from 29 September to 5 October 1974, with representation of 15 countries of Latin America and the Caribbean zones.

- Interregional meeting on the same subject, held in Quezon City, Philippines, 2-6 December 1974, with representation from Indonesia, Malaysia, Thailand and the Philippines.

5.2.1 Unit I. Antepartal care

Introduction

A trained TBA is expected to be involved in antepartal care. The main responsibility of the trainer, therefore, is to help the TBA to understand or reinforce her knowledge of the normal aspects of the expectant woman and recognize deviations from normal.

In caring for the expectant woman and her unborn baby, it is essential that the TBA orient and guide the mother, so that she will understand and learn how to cope with all aspects of her pregnancy.

The purpose of this section is to assist the expectant mother to reach term, ready and healthy, thus ensuring the birth of a healthy baby.

Main objectives

1. Manages the antepartal care of apparently normal women, in accord with guidelines provided by the trainer/supervisor.

2. Utilizes home visits to learn more about her client and to give needed advice and guidance on matters concerning the well-being of both the expectant woman and her unborn baby.

Main objectives

1. Manages, in accordance with guidelines, the antepartal care of apparently normal clients.

1.1 Learning objectives and learning tasks/skills

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify the location and functions of the female reproductive organs, both internal and external;	
(b) identify the location and functions of the male reproductive organs, both internal and external;	
(c) describe how the woman becomes pregnant;	
(d) describe changes that take place in the abdomen and related skin change during pregnancy;	- Identifies pregnancy
(e) describe breast changes during pregnancy, specifically enlargement, pigmentation and nipples;	- Appropriately performs physical examination of the expectant mother, with particular attention to the face, breasts, hands, legs, abdomen and vulva.
(f) describe other skin changes which may occur during pregnancy besides abdominal and breast;	
(g) describe changes in the size, shape and position of the uterus as pregnancy progresses;	
(h) describe how the baby grows;	
(i) describe the functions of the: placenta umbilical cord bag of water	
(j) describe how to calculate the estimated date of confinement;	- Determines the estimated date of confinement in accordance with acceptable guidelines.
(k) describe the procedure for assessing the normal progress of pregnancy including: abdominal palpation; assessment of fundal height; measurement of abdominal girth; location and auscultation of fetal heart tones.	- Estimates the normal progress of pregnancy and well-being of the unborn baby by appropriately performing the following techniques: palpation of the abdomen, assessment of fundal height, auscultation of fetal heart tones, and by measurement of the abdominal girth.
(l) identify the importance of urine testing during pregnancy;	- Appropriately carries out collection of urine for testing; Performs dipstick procedures for detection of albumin and sugar in the urine; Reports findings to the clinic or health service;

Learning objectives	Learning tasks/skills
(m) identify the significance of an adequate, well balanced diet during pregnancy, including knowledge of:	
variety and values of local foods;	- Identifies local foods and discusses their values;
selection of local foods (culturally acceptable and within the limits of the family budget) and amount of each that should be included in the daily diet of an expectant mother;	- Demonstrates how to prepare an adequate and well balanced diet to an apparently normal expectant woman;
adjustments which should be made in the diet when the woman is overweight or markedly underweight; or other conditions which require diet adjustments such as oedema, presence of sugar in the urine, etc.;	Discusses adjustments which should be made in the diet (as suggested in (m))
methods of preserving food;	- Demonstrates how foods can be preserved.
(n) identify common discomforts which a woman may experience during the childbearing cycle and TBA management, including knowledge of the following:	- Advises on and treats common discomforts associated with pregnancy, as mentioned in (n)
morning sickness heartburn constipation haemorrhoids varicose veins of legs and vulva vaginal discharge itching of the skin in the vulva area backache cramps of the legs inguinal pain urinary frequency and incontenence of urine	- Refers to the clinic or health service expectant women with severe discomforts.
(o) identify signs of approaching labour	- Identifies signs of labour.
(p) identify clients "at risk" and danger signs during pregnancy and TBA management, including knowledge of the following:	- Identifies danger signs during pregnancy.
bleeding from the vagina in the first few months of the pregnancy;	- Gives emergency care to expectant women with signs and symptoms of complications while awaiting professional assistance.
bleeding from the vagina in the last few months of pregnancy;	- Refers and accompanies clients to the clinic or health service if professional assistance is not immediately available.
excessive vomiting;	- Identifies clients "at risk" (women under 20, women over 35, primigravidae, grand multiparae, and women with histories of pathological pregnancies or childbirth) and refers them to the clinic or health service.
excessive weakness;	
excessive swelling of legs alone or combined with headache and epigastric pains, and/or convulsions;	
CVA (costo-vertebral angle) tenderness;	- Follows up expectant women with problems in accordance with the instructions of the clinic or health service.
headache and visual disturbance;	
sharp abdominal pain;	
disappearance of fetal movement.	

Learning objectives	Learning tasks/skills
(q) identify resources for referral of apparently normal clients or clients with conditions which can complicate the antepartal course	- Discusses procedures for referral of clients.

2. Utilize home visits to learn more about her clients and to give needed advice and guidance on matters concerning the well-being of both the expectant woman and her unborn baby.

2.1 Learning objectives and learning tasks/skills

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify expectant women's needs and problems by checking her condition during home visit	- Assesses the expectant woman's condition. - Appropriately observes, questions and listens to the expectant woman and her family to know as much as she can about their health and way of living. - Confirms findings with the trainer/ supervisor or other health personnel.
(b) explain what advice to give a woman and her family on proper care during pregnancy, according to identified needs, including knowledge of the following:	
(i) importance of antepartum check-ups in the clinic or health service, including antitetanus vaccine;	- Encourages clients to attend the clinic or health service. - Informs on hours of work and services of the clinic or health service.
(ii) personal hygiene;	- Appropriately advises on personal hygiene (clothing, bathing, care of the teeth, etc.).
(iii) importance of a clean house and surroundings in the prevention of disease;	- Advises and helps the family in making water safe, disposing of refuse and sewage, preventing food contamination and exterminating vermin around the house.
(iv) rest and sleep;	
(v) physical and emotional preparation for childbirth, including: exercises breathing techniques development of self-confidence	- Assesses the kind and amount of exercise the expectant woman is getting and advises accordingly. - Teaches and demonstrates specific exercises and breathing techniques which have been shown to help women cope with labour. - Reassures the expectant woman and family.
(vi) diet (refer to m above)	- Helps families to develop good eating habits within the limits of their own budget (refers to m above).

Learning objectives	Learning tasks/skills
(vii) methods of relieving discomforts of pregnancy;	- (refers to n above)
(viii) reasons for discontinuing sexual intercourse;	- Provides information to the expectant woman and her husband when possible about why and when sexual intercourse should be discontinued.
(ix) resources available for women/ couples desiring pregnancy spacing.	- Gives support to women's/couples' desire to space pregnancies. Provides information about appropriate available health resources. Refers or accompanies clients to family planning clinic.

Methods of Assessment*

Skills

Direct observation by the trainer/supervisor of the TBA performance in a real life situation (clients' home or clinic).

Direct observation by the trainer/supervisor of the TBA performance in a simulated situation.

Relayed information by competent others who are capable of observing and assessing the TBA performance.

Observation of the practical work of the TBA with individual expectant woman.

Observation of the practical work of the TBA with a group of expectant women in a clinic or community.

Knowledge

Oral questions or oral test about specific content objectives.

Oral questions or test about the total unit on antepartal care as planned by the trainer/ supervisor.

Interviews by the trainer-supervisor with individual TBAs.

Attitudes

Methods of assessing attitudes are more difficult. An attempt at appraisal would be made from:

direct observation by the trainer-supervisor of the TBA's interaction with clients;

oral questions or test;

group discussions;

interviews with individual TBAs.

* (Steps for assessing accomplishments and rating scales are included in 5.3).

5.2.2 Unit II. Intrapartal care

Introduction

It is the purpose of this unit to provide knowledge, skills and experiences needed to prepare the TBA to provide safe care to the woman during all stages of labour and to her newborn infant.

Some knowledge and skills learned in the antepartal course will be reinforced in this unit.

Main objectives

1. Manages the intrapartal and early postpartal care of apparently normal women, in accordance with guidelines provided by the trainer/supervisor.

2. Manages specified unexpected deviations from normal while waiting for skilled professional assistance.

3. Manages the care of the newborn infant during immediate extrauterine life.

Main objectives

1. Manages the intrapartal and early postpartal care of apparently normal women, in accordance with the guidelines.

1.1 Content objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA will be able to:	
Management of labour	
(a) identify signs of impending labour;	- Determines the stage of labour by identifying: the frequency, intensity and duration of contractions; abdominal pain or backache; pinkish discharge or "show"; waters break.
(b) identify advantages and disadvantages of giving an enema during labour;	- Gives enema appropriately.
(c) identify danger of giving an enema during labour;	
(d) identify the well-being of the unborn baby through knowledge of normal fetal heart rate;	- Listens to fetal heart tones accurately and identifies abnormalities.
(e) describe some common physical and emotional changes in the woman as labour progresses;	- Determines normal progress of labour without unnecessary interference or manipulation.
(f) identify some physical and emotional comfort and support measures which may help a woman in labour;	- Gives appropriate and safe care to the woman in labour, including backrub; position changes; presence of husband or other members of the family if culturally indicated; encourages passing of water, etc.

Learning objectives	Learning tasks/skills
(g) identify dangerous practice commonly used in connexion with labour and delivery;	
(h) identify appropriate time intervals for checking fetal heart tones and contractions;	- Checks fetal heart tones and contractions at appropriate intervals.
(i) describe appropriate food and drink for a woman during labour;	- Gives a very light diet early in labour and sweet tea throughout.
(j) identify factors that should be considered in selecting a site for birth;	- Selects appropriate site for birth.
(k) explain the appropriate preparation of birth site and of materials, supplies and equipment	- Appropriately uses the midwifery bag and equipment.
- for use in the delivery and the care of the mother and of the newborn infant;	- Prepares materials for use in delivery safely and completely.
- for herself;	- Appropriately cleans the vulva area.
- for perineal hygiene of the woman in labour;	
(l) explain the orientation for the family concerning:	- Informs the family of the progress of labour and appropriately advises and reassures the family.
- progress of labour;	
- type of assistance the family can offer the TBA;	
- type of assistance the family can provide to the woman in labour;	
(m) identify principles of clean and "extra clean" techniques as used in home delivery;	- Demonstrates techniques of boiling/sterilizing instruments.
Management of delivery	
(a) identify signs of impending delivery;	- Identifies signs of impending delivery.
	- Observes patient's behaviour at this stage of labour.
(b) identify the procedures for delivering a baby in a culturally approved position;	- Uses safe techniques for delivering a baby.
(c) identify when to advise a woman to bear down;	- Uses appropriate techniques in cases of unexpected occurrences.
(d) identify the following:	
- how to prevent too rapid birth;	
- what to do as soon as the baby's head is born;	
- what to do if the bag of water has not broken when the baby's head is born;	
- what to do if the cord is around the baby's neck;	
- how to deliver the rest of the body;	
- what to do when the shoulder gets stuck;	
- how to prevent perineal tear and what to do when tears occur.	

Learning objectives	Learning tasks/skills
Separation and expulsion of the placenta	
(a) identify signs of separation of the placenta;	- Identifies signs that the placenta has separated.
(b) explain methods of delivering the placenta without pulling on cord or membranes;	Uses safe techniques to deliver the placenta.
(c) describe the appearance of a normal term placenta and how to inspect the placenta for completeness;	Thoroughly examines the placenta.
(d) explain the significance of malodorous placenta;	
(e) identify how to estimate the blood loss;	- Checks the fundus frequently to see that it is contracting satisfactorily.
(f) explain how to control excessive blood loss;	- Checks bleeding frequently. Estimates blood loss accurately. - Appropriately massages the uterus to control excessive blood loss. - Examines mother for any lacerations. - Makes mother clean and comfortable.
(g) describe the orientation to be given to the mother and her family concerning: - appropriate food and drink, immediately after delivery; - perineal care; - rest, appropriate time to leave the bed and activities; - care of the newborn infant;	- Gives appropriate orientation and advice to mother and family.
	- Discusses with the family the method for disposal of the placenta or delivers the placenta to the family for disposal according to local tradition. - Gives complete report on client to the trainer and informs the health centre of the delivery attended and its results. - Fills out simple intrapartal report form, where appropriate.

2. Manages specified unexpected deviations from normal while waiting for skilled professional assistance.

2.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify danger signs and symptoms during labour and TBA management including knowledge of the following:	- Detects danger signs during labour by appropriately observing and examining the patient.

Learning objectives	Learning tasks/skills
- prolonged labour;	- Communicates need for expert assistance (physician or midwife).
- bleeding before the baby is born;	- Institutes immediate care and appropriately manages the following unexpected conditions until physician or midwife arrives: - prolonged labour - bleeding before the baby is born - convulsion during labour
- convulsions during labour;	- Accompanies patient to clinic if expert assistance is not available at home.
(b) identify complications during delivery in connexion with the ways in which a baby can be born and TBA management including knowledge of the following:	- Detects signs that indicate breech or shoulder presentation by inspection of fundal height, palpation and auscultation of fetal heart tones.
- breech (buttocks or feet) presentation;	- Calls for immediate assistance of a physician or midwife.
- when hand or hand and arm appears first; - when cord comes first.	- Initiates care and appropriately manages the following complications until physician or midwife arrives: - breech presentation - shoulder presentation - prolapse of cord

3. Manages the care of the newborn infant during immediate extrauterine life.

3.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify the significance of maintaining proper environmental temperature for the newborn baby;	- Maintains proper environmental temperature for the newborn by: - quickly completely drying the infant; - removing all wet material from contact with the newborn; - wrapping the newborn in prewarmed cloth or warm blanket.
(b) identify the establishment of the baby's breathing and TBA management if the baby does not breathe as it should.	- Maintains air passage clear: - wipes excess mucus and "waters" from baby's face; - positions infant to facilitate proper drainage of mucus; - Observes the baby for signs of distress. - Appropriately stimulates breathing, including mouth to mouth breathing, if indicated. - Sends for professional assistance when it has been difficult to start breathing.

Learning objectives	Learning tasks/skills
(c) identify baby's needs for appropriate care and TBA management, including knowledge of the following:	
- best time to tie and cut the cord; - procedure for tying and cutting the cord;	- Appropriately ties and cuts the cord.
- how to care for the umbilical stump;	- Keeps cord clean and dry to aid its separation. - Reports any discharge or foul smell.
- how to care for the eyes;	- Appropriately cares for the eyes. - Reports immediately any discharge.
- how to give skin care and why immediate bath should be avoided;	- Gives appropriate skin care.
(d) identify high risk infants and infants with deviation from normal and TBA management, including knowledge of the following:	- Performs newborn examination. - Identifies high risk infants.
- how to tell when a baby is born too soon or is immature;	- Confirms observation with trainer/supervisor or other health personnel.
- what to do and what to tell the family to do when the TBA has to wait several hours for a physician or midwife to come; - how to take care of an immature baby; - how to take care of a baby with malformation; - how to take care of a baby with birth injury;	- Appropriately gives and shows the mother and one member of the family how to give care to a newborn baby in case of: - immaturity; - malformation; - birth injury; - Calls for appropriate assistance when there is any abnormal symptom which gives rise to concern. - Determines and reports to the clinic or other available health service significant aspects of newborn's extrauterine course, when indicated.
(e) identify measures to begin mother-infant family relationship.	- Gives baby to mother/family to hold if baby's and mother's condition allows. - Helps mother with breast feeding, if baby's and mother's condition allows.

Methods of assessment*

Skills

Direct observation by the trainer/supervisor of the TBA's performance of every skill or task included in each of the selected learning objectives in real life situations (e.g. when conducting delivery in the client's home or clinic).

* (For steps in assessing accomplishments and rating scales refer to 5.3).

Direct observation by the trainer/supervisor of the TBA's performance in a simulated situation, when appropriate (e.g. how to clean or sterilize instruments to be used in home delivery).

Relayed information by competent others (doctors, nurse-midwives, midwives), who are capable of observing and assessing the TBA's performance.

Knowledge

Oral questions or tests about each one of the content objectives.

Oral questions or tests involving the total intrapartal care as selected and organized by the trainer/supervisor.

Interviews.

Attitudes

Methods of assessing attitudes are more difficult. An attempt at appraisal could be made from:

Observation of practical work of the TBA.

Oral test or questions.

Interviews.

Group discussions.

Observation of TBA's interaction with clients/family and health workers.

5.2.3 Unit III. Postpartal care

The purpose of this unit is to provide knowledge, skills and experience needed to prepare the TBA to provide safe care whereby the woman can recuperate physically and emotionally from her experience during recent pregnancy and labour.

It includes content related to the normal as well as abnormal puerperium.

Some knowledge and skills learned in previous sections will be reinforced.

Main objectives

1. Manages the postpartal care of women, according to guidelines provided by the trainer.
2. Utilizes the stay in the client's home or home visits to continue postpartal care and to add to the well-being of her clients and their family.

1. Manages the postpartal care of women, according to guidelines provided by the trainer.

1.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify normal changes in the uterus, abdomen and breasts during the puerperium;	- Recognizes normal changes in the woman during the puerperium. - Estimates the height of the fundus and consistency of the uterus. - Examines the perineum: observes for bruised or swollen tissue.

Learning objectives	Learning tasks/skills
	- Checks for abdominal distention and fullness of bladder. - Examines the condition of the breasts: observes for signs of engorgement and cracked nipples.
(b) identify the changes that appear in lochia postpartally and the approximate time that each change appears;	- Checks the kind, amount and odour of lochia.
(c) explain what advice to give a new mother on how to breastfeed her newborn infant if she has had no previous experience, including knowledge of the following:	- Encourages the mother to breastfeed her baby. - Advises regarcing appropriate preparation and techniques of breast feeding.
- when to feed; - length of time to nurse the first few days; - what to do for sore nipples;	- Advises mother to report if her nipples are tender. - Thoroughly examines the nipples for fissures. - Initiates prompt treatment, including advice to mother on what to do. - Performs technique of manual expression of milk.
- how to deal with engorged breasts;	- Recognizes signs and degree of engorgement. - Initiates appropriate treatment and advises the mother on what to do in case of: - slight engorgement; - severe engorgement. - Correctly applies a supportive breast binder.
- normal length of time necessary for lactation; - how to determine whether baby is getting enough milk;	- Recognizes signs of underfeeding. - Appropriately advises on treatment, including: - reassurance to mother/family; - complementary feeding, given temporarily; - appropriate diet to the mother; - increasing the frequency of feeding time.
(d) identify complications of the postpartal period and TBA management, including knowledge of the following:	- Recognizes signs and symptoms of the following complications in the mother:
- puerperal infection; - delayed bleeding; - urinary retention; - urinary tract infection.	- puerperal infection; - delayed bleeding; - urinary retention; - urinary tract infection.

Learning objectives	Learning tasks/skills
	- Initiates measures to relieve the above conditions, as instructed - Promptly refers and/or accompanies patient to the health service when above conditions are detected or suspected. - Reassures the patient/family.

2. Utilizes the stay in the client's home or home visits to continue postpartal care and add to the well-being of her client/family.

2.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to: (a) explain what advice to give mother/family including knowledge of the following:	
- hygiene of hands, breasts and genitals;	- Teaches the mother necessary skills in caring for herself and her baby, in accordance with identified learning needs. - Involves the family in her teaching. - Demonstrates breast and perineal care.
- importance of adequate diet for the mother and her baby;	- Demonstrates preparation of complementary feeding for the baby, when indicated.
- importance of prolonged breastfeeding for the baby and the mother;	- Encourages prolonged breastfeeding and explains to mother and family why it is important for the mother and her baby. - Advises on kinds of food (culturally acceptable and within the family budget) and daily amount of each the mother needs to build up her strength and to enable her to produce sufficient milk.

- appropriate activity/exercise for the mother;	- Gives specific instructions regarding activity exercises for the mother, including:
	  - when to be out of bed;
	  - gradual resumption of normal household duties;
	  - specific exercises to bring the stretched abdominal and pelvic muscles back to normal as quickly as possible.

- when sexual intercourse of the couple may be resumed; - when menstruation starts; - relationship between the first postpartal menstruation and possible fertilization;	- Discusses an appropriate time for resumption of sexual intercourse.

Learning objectives	Learning tasks/skills
- benefits of spacing pregnancies;	- Explains advantages of spacing pregnancies. - Discusses when the mother should attend the family planning clinic, if the couple wish to control the spacing of their family.
- registration of birth;	- Encourages parents to register the birth of the baby. - Assumes the duty of reporting the birth of the baby, should the parents neglect to do so.
- significance of postpartal examination and subsequent health check-ups for the mother and her child;	- Refers mother for postpartal examination. - Encourages periodic health check-ups for the mother and her baby in the nearest clinic or health service.
(b) identify the important part that a clean house and surroundings play in the prevention of disease.	- Advises and helps family in creating and maintaining a clean environment (reinforces advices given during the antepartum period). - Reports findings and results of her interventions during the postpartal period to the health services.

Methods of assessment*

Skills

Direct observation by the trainer/supervisor of the TBA's performance or practical work in real life situation (client's home or clinic).

Direct observation by the trainer/supervisor of the TBA's performance in a simulated situation.

Relayed information by competent others who are capable of observing and assessing the TBA's performance.

Observation of the practical work of the TBA with individual clients or group of clients.

Knowledge

Oral questions or tests about specific content objectives.

Oral questions or tests about the total postpartal unit as planned by the trainer/supervisor.

Interviews by the trainer/supervisor with individual TBA.

Observation of application of knowledge in performing skills.

Attitudes

Methods of assessing attitudes are more difficult. An attempt at appraisal could be made from:

* (For steps in assessing accomplishments and rating scales refer to 5.3).

Direct observation by the trainer/supervisor of the TBA's work including interaction with clients/family and health workers.

Relayed information on TBA's attitude by other competent persons who are capable of observing and appraising the TBA's attitude through her performance.

Oral questions or tests.

Interviews.

5.2.4 Unit IV. Interconceptional care (family planning)

The purpose of this unit is to provide the knowledge and skills needed to prepare the TBA to understand the role of family planning in maternal and child health and to participate in family planning activities. Simple elements of reproductive physiology learned in the antepartum course will be reinforced in this unit.

Main objective

Motivates the community in the use of methods for spacing pregnancies (in conformity with the policy of each country) and appropriately advises women/couples desiring or utilizing a pregnancy spacing method or with infertility and other problems.

1. Main objective

Motivates the community in the use of methods of spacing pregnancies and appropriately advises women/couples desiring or utilizing a pregnancy spacing method and with infertility and other problems.

Learning objectives	Learning tasks/skills
At the end of this unit the TBA is able to:	
(a) identify the significance of pregnancy spacing to parents who have three or more children, and who are poor, living in overcrowded houses, or where the mother is sick;	- Supports woman's/couple's desire for spacing pregnancy. - Gives appropriate information to her clients and determines their understanding.
(b) explain what advice to give women/couples desiring or utilizing a pregnancy spacing method, including knowledge of the following: - different methods of pregnancy spacing; - resources available to women/couples;	- Communicates with other health team members, as necessary. - Participates with health team members and community leaders in talks with couples and groups.
(c) identify side effects of contraceptives (IUDs and contraceptive pills) differentiating between those which are of lesser significance and those which are more severe;	- Reassures women with common non-significant side effects of contraceptives. - Remotivates discontinuing users.
(d) explain what advice to give women on any discomfort or abnormalities which may arise;	
(e) explain what advice to give women/couples with infertility problems.	- Refers or accompanies to the health establishments women/couples desiring to space pregnancies, users of IUDs and contraceptives for periodic check-ups, users with significant side-effects of contraceptives, women/couples with infertility or other problems. - Informs the staff of the health establishment of any unfavourable rumour that might undermine family planning.

Methods of assessment*

Skills

Observation of practical work in homes and communities related to pregnancy spacing or infertility problems.

Relayed information by other competent persons who are capable of observing the TBA's performance (e.g. number of eligible individuals/couples either directed or brought by the TBA to family planning clinics).

Knowledge

Oral questions or tests related to each one of all content objectives of the interconceptional course.

Interviews with individual TBAs.

Clients' response to modern methods of family planning.

Attitudes

Methods of assessing attitudes related to pregnancy spacing are particularly difficult and probably require a large sample of her behaviour. An attempt at appraisal could be made from:

Relayed information by other competent persons who are capable of observing and assessing her performance, when participating in talks with couples and groups, in referring or accompanying clients desiring to space pregnancies to clinics, etc.).

Group discussion.

Interviews with individual TBAs.

Clients' response to modern methods of family planning.

5.2.6 Unit V. Infant care

Introduction

The TBA who comes in contact with so many families in her community has an important role to play in child-rearing practices.

It is the purpose of this section to provide the knowledge, skills and experience needed to prepare a TBA to provide appropriate care to infants.

Main objectives

1. Manages the apparently normal infant, in accordance with the management guidelines provided by the trainer/supervisor and manages with professional health personnel infants who develop complications.

2. Utilizes home visits to obtain additional information on the infant's well-being and to give advice and guidance to mother/family on infant care, in accordance with identified learning needs.

* (For steps in assessing TBA's achievements and rating scale refer to 5.3).

Main objectives

1. Manages the apparently normal infant in accordance with guidelines provided by the trainer/supervisor and manages with professional health personnel infants who develop complications.

1.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify normal progress of infants from birth through twelve months, including knowledge of normal child growth and development;	- Estimate normal progress or signs of thriving by observing the infant's behaviour, in accordance with guidelines on some of the more specific patterns of behaviour of a normal child, such as: - takes food eagerly; - gains weight; - appears bright and alert; - muscles show increasing strength, beginning with an ability to lift his head at about three months until by the end of the year he can stand or walk; - sleeps well and is not constantly irritable; - begins to say one or two words by the time he is one year, etc. - Confirms her observations with trainer/supervisor. - Refers infants who are failing to thrive to health service or clinic.
(b) identify the primal needs of infants including knowledge of the main factors which contribute to the health and happiness of the infant, such as: - mothering; - adequate feeding; - rest and sleep; - fresh air and exercise; - safety: protection from infection and other environmental hazards;	- Assesses the needs of the infant and the resources of the home. - Discusses factors which impair the development of the normal mother/child relationship. - Discusses factors which impair the provision and maintenance of a suitable physical environment for the infant.
(c) identify the significance of immunizations in the prevention of diseases and of periodic check-ups of apparently well infants in the health service or clinic.	- Ensures that facilities for continuing care are available and that the family is aware of them.
(d) identify facilities available for continuing care of the infant.	
(e) identify infections and disorders commonly associated with childhood and TBA management of each, including knowledge of the following:	- Determines that any one of the conditions mentioned in (e) has occurred by observation, physical examination or information from the mother/family.

Learning objectives	Learning tasks/skills
- sore buttocks; - skin rashes and infections; - dehydration fever; - convulsions; - diarrhoea; - persistent vomiting; - obvious pain or extreme listlessness; - eye infection; - spasms and stiffness of neck and jaw; - bouts of coughing followed by whooping and vomiting; - respiratory difficulties;	- Confirms problem identification with trainer/supervisor or other health personnel. - Identifies among these problems the ones which warrant immediate professional assistance and refers infants to the health service or clinic. - Cooperates with health professional by reporting findings and carrying out their instructions.
(f) identify measures for prevention of each one of the above-mentioned problems.	- Discusses measures for the prevention of the infections and disorders of infancy mentioned in (e).

2. Utilizes home visits to obtain additional information on the infant's well-being and to give advice and guidance to mothers/family on proper infant care, in accordance with identified learning needs.

2.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the TBA is able to:	
(a) identify mother's/family's learning needs, taking into consideration previous experience of the mother in caring for their infants (what/how she knows);	- Gives appropriate information and instruction to mother /family in accordance with identified learning needs, followed by demonstration where applicable.
(b) explain what advice to give mother / family including knowledge of the following:	
- importance of proper feeding practices for the well-being of the infant and the fostering of good mother/infant relationships;	- Gives appropriate instruction to mother / family on infant diet from birth through twelve months for both breast-fed and formula-fed infants including supplementary locally available foods and when each one should be introduced, and supplementary foods which should be introduced in the weanling diet (composition, preparation and giving of food).
- cleanliness of infant;	- Demonstrates bathing techniques. - Advises mothers to change napkins or diapers when soiled or wet and to wash the infant's buttocks to prevent sore buttocks.
- measures for prevention and control of any communicable diseases prevalent locally;	- Discusses with mother need for immunization and immunization schedule through the first year of life.

Learning objectives	Learning tasks/skills
	- Discusses and demonstrates other measures for prevention and control of communicable diseases, such as: - proper waste disposal; - clean food handling; - destruction of breeding places for flies and mosquitos; - hand wash routine after toilet; - extermination of rodents, etc.
- importance of having diseases of the infant attended to at an early stage;	- Teaches how to maintain a safe physical environment in the home and surroundings.
- measures to prevent accidents in the home;	- Teaches simple first aid techniques in the home.
- importance of regular infant check-ups in a clinic or health service	- Arranges for visits of infants to clinic or health service.
	- Encourages mother's participation in classes on infant health care at the health service.
	- Arranges with mothers/family home visits schedule.

Methods of assessment*

Skills

Direct observation by the trainer/supervisor of TBA's performance in real life situation (in the client's home or clinic).

Direct observation by the trainer/supervisor of the TBA's performance in a simulated situation.

Relayed information by other competent persons who are capable of observing and assessing the TBA's performance in a clinic or client's home.

Knowledge

Oral questions or tests on each content objective included in the main objectives of the Infant Care Unit.

Oral questions or tests on the contents of the total unit.

Observation of the TBA's practical work in advising mothers/families on appropriate infant care.

Interviews.

Attitudes

Methods of assessing attitudes are more difficult. An attempt at appraisal could be made from:

Group discussions on infant care;

Interviews;

Observation of the TBA's practical work with mothers/families.

* (For steps in assessing TBA's achievements and rating scale refer to 5.3).

5.2.7 Unit VI. Coordination of the activities of the Traditional Birth Attendant with the health service and the community

The function of the TBA is primarily that of caring for women and their newborn infants during the maternity cycle. However, her welcome presence in homes and her status in the community places her in a favourable position to cooperate with the health service in community health.

While her limitations as a community health worker are acknowledged, she should be able to recognize when someone is sick and should know how and where the person can be helped.

The main purpose of this unit is to provide the elementary knowledge and skills needed to prepare a TBA to serve as a link between the community where she practises and the available health and local social welfare agencies.

Content of this unit is applicable to all aspects of the TBA practice. Its specific content objectives and learning tasks have, to a great extent, been incorporated in the antepartal, postpartal, and infant care units.

Main objective

Coordinates her activities with the health and local social welfare agencies and, as a collaborator of the health team, carries out her part in such a manner that it supports the work of all.

Main objective

1. Coordinates her activities with the health and local social welfare agencies and, as a collaborator of the health team, carries out her part in such a manner that it supports the work of all.

1.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this unit the TBA is able to:	
(a) explain how to contact the available health and local social welfare agencies;	- Informs her clients and families of the services provided by the health and local social welfare agencies and how to contact these agencies.
(b) describe: - the type of assistance she herself, her clients and the community at large can receive from these agencies; - the health personnel to call in emergencies and those for referral of clients with particular problems;	- Promotes the use of the health and other agencies available to the community.
(c) identify community health problems and TBA management including knowledge of the following: - signs and symptoms suggestive of the most common communicable diseases in the area; how they are spread and how they can be prevented; - sanitation problems; - accident hazards;	- Informs the trainer/supervisor or the staff of the health service of identified community problems, including: - outbreak of any communicable disease; - sanitation problems; - other home and community problems that have a bearing on disease and its treatment;

Learning objectives	Learning tasks/skills
(d) identify the importance of notifying the appropriate agency or agencies: - home and community factors that have a bearing on disease and its treatment;	- Carries out the instructions of the health staff. - Teaches families: - how to protect themselves and others when there is a communicable disease in the home or neighbourhood; - how to prevent accident hazards; - first aid in the home; - Informs the staff of the health service of her activities, as appropriate. - Attends meetings arranged by the health service.
(e) describe her role as a collaborator of a health team.	

Methods of assessment*

Skills

Observation of TBA's performance as it relates to community health problems.

Observation of TBA's performance as it relates to cooperation with health and social welfare agencies in the community.

Relayed information by other competent persons who are capable of observing and assessing her work as a community health agent and collaborator of a health team.

Knowledge

Oral questions or tests on each of the content objectives included in the section and on the section as a whole.

Interviews with individual TBAs.

Attitudes

Methods of assessing attitudes are more difficult. An attempt at appraisal could be made from:

Observation of the TBA's attitude when participating in community or health service meetings.

Interviews.

Group discussions.

5.3 Steps for assessing the training programme

Assessment of behavioural changes (knowledge, skills, attitudes) that may be occurring in the TBA during training should be made continuously throughout each section and at the end of each unit.

* (For steps in assessing TBA's achievements and rating scale refer to 5.3).

It is not possible to fully assess a training programme by the appraisal of the TBA performance at the end of the programme.

Methods and techniques of assessment as well as the sequence of the steps involved in the appraisal process are practically the same for all units included in the total programme.

5.3.1 Identification by the trainer of the situation or situations which will give the TBA the opportunity to express the behaviour implied by each learning objective. For example, if the trainer is going to see how TBAs are developing skills in the safe conduct of normal childbirth (Unit II. Intrapartal care, learning objective b), she must use those situations which not only permit the expression of this behaviour, but actually encourage or evoke it. This means looking for evidence of the TBA's skill in conducting safe delivery, by being present at the client's home or in a clinic, when the actual birth is taking place and being attended by the TBA.

5.3.2 Methods of assessment

Observation. As, in general, most TBAs cannot read or write, one of the assessing devices most commonly used is the observation of the TBA's behaviour. Some content objectives such as assessing the normal progress of pregnancy (Unit I. Antepartal care, learning objective k) are more easily and validly appraised through observations in real life situations of the TBA's techniques of abdominal palpation, assessment of fundal height, auscultation of fetal heart tones and measurement of the abdominal girth and her correct interpretation of findings (as checked by the trainer/supervisor).

Interview. Well conducted interviews may throw light upon changes taking place in attitudes and interests, such as in learning objectives regarding modern methods of pregnancy spacing. However, the interview as an assessment instrument may have limitations owing to language barriers.

Questions, expressed verbally, may also give evidence of knowledge, attitudes and interests of the TBA.

Any way of getting valid evidence about the kinds of behaviour aimed at by the learning objectives is an appropriate assessment procedure.

5.3.3 Recording the TBA's behaviour. It is important to get some record of the TBA's reactions in the situation, if there is to be an opportunity to appraise their reactions after they have been made. This involves making a detailed description of the TBA's reactions by the trainer, or the use of a check-list by which the trainer checks off particular types of behaviour that commonly appear.

Whether the trainer takes notes in the presence of the TBA, or writes them later, in privacy, depends on the personality of the TBA and the relationship the trainer establishes with her. If the TBAs understand why the trainer is taking notes, and have accepted the training programme, note-taking may not affect them. In general, it is better to write down notes after the observation.

5.3.4 Summarizing the information obtained. Every kind of behaviour which is appraised for its part as a content objective, should be summarized with indications of its weaknesses and strengths; this is so as to describe more adequately the degree of achievement of each particular learning objective. We may take as an example the learning objective in the area of nutrition for a pregnant woman (Antepartal care, objective 1, sub-objective m) "Kinds of local foods that an apparently normal expectant woman should eat". The knowledge acquired by TBAs in this area may be measured by the number of different items of diet - "fruit" or "raw vegetable", "milk", "lean meat", "green or yellow vegetable", "eggs", "cereals" (should they be locally available and culturally acceptable) - they were able to remember or mention. This kind of summary, which indicates particular strengths and weaknesses, is invaluable in using the results to improve training.

5.3.5 Determining the adequacy of a sample behaviour. It is also necessary for the trainer to determine how large a sample of behaviour regarding a given learning objective should be collected from which to draw conclusions on the TBA's achievement. For instance, if the trainer wishes to get evidence about the skill of the TBAs in "infant bathing technique" it may take a

few samples, or a few observations of this behaviour to get a reasonably dependable indication of the degree of skill of each Traditional Birth Attendant. On the other hand, if there is a wide variability in the Traditional Birth Attendant's attitudes, as for instance regarding pregnancy spacing (the Traditional Birth Attendant may agree that a small family lightens the burden of life but, nevertheless, hold strong religious convictions that God will make the decision and to limit birth is a direct interference with God's will), it will take a much larger sample of her behaviour to infer reliably about the degree of her acceptance or rejection of family planning.

It is not possible to be sure in advance how large a sample of behaviour must be collected regarding a given objective, in order to draw conclusions about the status of the Traditional Birth Attendant's knowledge. If a set of observations does not give an adequate sample of the Traditional Birth Attendant's behaviour, it will be necessary for the trainer to extend the sample before dependable conclusions can be drawn.

5.3.6 Using the results of evaluation. The results obtained from evaluation instruments (observation, interview, verbal questions, etc.) will give an analytical profile indicating the present achievement of the Traditional Birth Attendant. These results or profile should be comparable to those obtained at a preceding date so that it is possible to indicate changes taking place. If it is shown that the ability to conduct safe and clean childbirth is no greater at the end of the last appraisal than it was in a previous one, no behavioural change is taking place. It is therefore necessary to compare the results obtained from several evaluations in order to estimate the amount of change taking place, and to identify strengths and weaknesses that will help to indicate where the training requires improvement.

It is also necessary to suggest possible explanations about the reasons for a particular pattern of weakness or strength. These possible explanations should be checked against all the available data to see whether the explanations are consistent. If they appear to be consistent, and the programme reveals areas of weakness, then the final step is:

- to modify the training programme or appropriate sections of the programme and/or the methodology or approach used in the direction implied by the explanation and then try out the modified programme and/or approaches to see whether there is an actual improvement in the Traditional Birth Attendant's performance when these changes are made.

5.4 An example of rating scale that can be learner/supervisor rated.

Rating Scale*

TBA's name _____

Can perform the designated task properly, with initiative and adaptability and can lead other TBAs in performing this task.	5
Can perform the designated task properly, with initiative and adaptability to specific problem situations.	4
Can perform designated task satisfactorily with some supervision and/or assistance.	3
Can perform designated task satisfactorily but requires regular or periodic supervision and some assistance.	2
Can perform designated task but not without constant supervision and/or assistance	1
Cannot perform designated task satisfactorily for its inclusion within her function in a maternal and child health programme.	0

Trainer/supervisor's name _____

* Adapted from Canada Newstart Programme, DACUM. Approach to curriculum, learning, and valuation in occupational training, by R. E. Adams, Nova Scotia, March 1972.

The minimal level of competence expected in each task is level 3. It may be lowered to level 2 depending on the resources of the health services (and therefore on the availability of a competent health worker) to provide regular on-the-spot supervision to individual Traditional Birth Attendants.

Below these levels, there are two others: at level "1" the TBA has ability to perform mechanically the designated tasks but must work under direct constant supervision of health personnel and requires considerable assistance. This is rarely possible in rural remote communities and therefore was classified below the acceptable level of competence for TBA's participation in MCH programmes. At level "0", the TBA has not mastered the necessary minimal skills for involvement in the programme.

Above the baseline "3", there are also two other levels: level "4" requires increased ability to apply skills efficiently and to use initiative when unexpected occurrences arise during the maternity cycle. Level "5" requires, in addition to the level "4" skills, ability to verbalize her skills, enabling the TBA to lead her peers.

The rating scale should be used for every skill or task included in each of the content objectives. It is suggested that the rating scale should be used immediately on the TBA's entry to the programme and periodically, over a period of time, to identify changes that may occur when the TBA has had an opportunity to practise the same skills during training and therefore demonstrate the degree of her ability.

The rating scale is based on performance. There are three levels of observation that can be applied in making assessment and granting ratings:

(1) directly observed performance by the trainer/supervisor;

(2) observation through oral questioning or oral test;

(3) relayed information by other competent persons who are capable of observing and assessing the TBA's performance.

An example is given below.

TBA's name: Date:

Objective: Manages the care of the newborn infant during immediate extrauterine life.

Tasks	Tasks Performance						Comments
	0	1	2	3	4	5	
- Maintains clear air passage				✓			
- Identifies signs of respiratory distress			✓				
- Demonstrates how to stimulate breathing			✓				
- Maintains proper environmental temperature for the newborn					✓		
- Appropriately ties and cuts the cord				✓			
- Demonstrates how to care for the umbilical stump				✓			
- Demonstrates how to care for the eyes				✓			
- Identifies high risk infants and appropriate TBA management			✓				
- Identifies sources of referral for continuity of care						✓	
Others:							

1. Check in the corresponding column - 0, 1, 2, 3, 4, or 5, according to the degree of competence observed in the TBA's performance in each one of the tasks mentioned in column 1; rated according to the rating scales.

2. Specify weaknesses and/or strengths observed in each of the tasks mentioned in column 1 and give possible explanations for patterns of weaknesses or strengths.

5.4 Approach to learning and training methods

In developing the programme content it is the responsibility of the trainer to help the Traditional Birth Attendants to have their needs met in a way that is not only satisfying but provides the kind of behaviour patterns that are personally and culturally significant.

An approach, which might prove highly successful in the introduction of new practices, is to define the cultural background of whatever community the programme is contemplated for and to analyse and apply the findings in such a way as to avoid unnecessary conflict with existing cultural patterns.

Another important motivation for the acceptance of a change is some practical benefit. The Traditional Birth Attendant will accept changes if she is truly convinced that the new practice is advantageous - either through a convincing demonstration in the home of her clients or in the environment where it is to be applied, or because the new practice has the support of a person of high prestige in the community.

Training methods

Starting a training course composed of adults with entrenched attitudes and values and who are already considered learned practitioners may seem difficult. The trainer has to employ a variety of educational methods not only to maintain the interest of the Traditional Birth Attendant but to make learning more effective and permanent. To overcome the problems of verbal communication, non-verbal communication methods should be utilized to facilitate effective interactions. Some of the methods considered most helpful are presented. However, it should be kept in mind that no training method is worth much without warmth, genuine concern, interest and skill of the trainer.

(a) Demonstration:

Skills and their perfection are best learned through demonstration and practice. In conducting a demonstration, the trainer should reproduce with as much realism as possible the environment and the situation in which the Traditional Birth Attendants work. The materials and equipment to be used should only include those articles available to the Traditional Birth Attendants in their practice. All the materials needed for the demonstration should be prepared and conveniently organized to facilitate their use.

New methods or practices to be demonstrated should be adapted to traditional ones rather than vice versa. For example, if the trainer could adapt her methods of delivering a baby, and allow delivery in the native traditional position - kneeling or sitting up position - it might reduce emotional tension in the Traditional Birth Attendants and their clients. The Traditional Birth Attendant might also be less resistant to new restrictions or additions which need to be demonstrated for safe conduct of childbirth such as to hold the legs of the woman without injuring the hip joint, which may be dislocated when the legs are pulled too far apart.

A good demonstration involves telling, listening, showing, doing so that the procedure can be easily understood by the Traditional Birth Attendants. It should be kept simple and clear for all to see and understand.

A return demonstration by the trainee should follow closely in order to determine whether she can satisfactorily perform the procedure demonstrated. This should be carefully supervised in all its details to avoid errors that may go unnoticed. Practices of procedures or techniques found difficult should be repeated until she has developed the skill and the habit of performing them correctly. If the trainer observes some mistakes in the procedure, she

should guide the Traditional Birth Attendant patiently until the latter has gained insight into why and how the procedure should be done in this way. Once insight has been gained the procedure should be repeated as many times as needed until the Traditional Birth Attendant has reached maximum performance. After each part of the procedure has been mastered, the whole procedure from the beginning to the end should be re-demonstrated by the trainee so that she will be able to relate the different steps together and to perceive the procedure as an integrated whole.

The utilization of trained Traditional Birth Attendants (if available in the community) as demonstrators, may influence their peers to change their attitude towards new practices and improve their performance.

Although the demonstration by the trainer is directed at the group, individual attention should be given to slow learners, i.e. those with some degree of decreased learning ability and motor slowness due to aging. For the trainer to give up on a Traditional Birth Attendant before she is able to perform a given skill, because of physical slowness, is damaging to the Traditional Birth Attendant's self-esteem and may be detrimental to her potential for better functioning. The trainer should, therefore, assess the trainees' qualities and not expect the group to advance together from one experience to another.

(b) Group discussion:

Properly organized group discussions can be one of the most complete of those methods which rely, principally, on verbal communications. It is especially useful in teaching controversial subjects, such as family planning. It enables each member of the group to hear facts and examples from many points of view as well as her own. Discussions should be conducted in the local language and preferably under the guidance of selected trained Traditional Birth Attendants, who should be briefed in advance on methods of discussion. Discussion questions should be selected on the basis of the current knowledge, experiences, needs and interests of the Traditional Birth Attendant trainees. The effectiveness of group discussions depends upon careful selection of appropriate questions of particular interest to the group, their organization in the right order and the use of a non-directive or at most semi-directive approach to ensure spontaneity. The role of the trained Traditional Birth Attendant, as discussion leader, is to keep the discussion going without expressing her own opinion on any question being discussed and to assist the trainees in designing a plan of action which represents the consensus of the group. Discussion of a carefully prepared list of questions is an effective means of bringing Traditional Birth Attendants to accept the idea of change.

Trained Traditional Birth Attendants who have participated in group discussions may also assist in the implementation and supervision of the actions planned and approved by the trainees.

(c) Acting out a particular situation:

The use of this method in the training of Traditional Birth Attendants will provide opportunities for much more active participation by group members than do many other educational methods. The situation selected should be simple and realistic enough to allow the Traditional Birth Attendants to gain insight into their own and others' feelings. It is important that group members have the experience of discovering that they can explore a problem, break it down into factors which may be causing it, and construct ways of meeting the problem through changing the situation or their behaviour.

The trainer should only choose this method when she believes that it is particularly useful in focusing a problem that is meaningful and important to the whole group. She should be skilful in helping the Traditional Birth Attendants to be spontaneous in presenting the characters that they are portraying and in helping the other trainees to analyse the situation and behaviour presented. In so doing, she will be increasing their understanding of problems and their knowledge in dealing with them.

(d) Lecture:

Lecture is not considered an effective means of adult education, especially for illiterate or non-educated older persons. Lectures are usually highly directive and should, therefore, be avoided.

Whatever method or methods used, the trainer "must be very careful to set up procedures that pose no major threats to the Traditional Birth Attendants' faltering self-esteem. This can be achieved by assessing the Traditional Birth Attendants' abilities and by pacing the amount and content of information so that they will not fail to succeed, particularly in early attempts". (p. 164 of reference 3). Any method of communication must be delivered in such a manner that the Traditional Birth Attendants' intelligence and knowledge are not belittled.

5.5 Educational aids

The aforementioned educational methods can be greatly improved and rendered more effective with the use of real life situations in the home or the clinic. Audiovisual materials such as mannequins, models, posters, flip charts, flannelgraphs, filmstrips, etc., should preferably be made locally and where possible with participation of the trainer and the Traditional Birth Attendants themselves. Posters should be arresting in colour and design, conveying the message at once. Advice given should always be positive; bad practices should not be depicted. Flannelgraphs are excellent to depict generative organs, position of baby in the uterus, etc. Blackboards are valuable in teaching step-by-step while building up a drawing. Coloured chalk should be used to give emphasis and variety. It permits the showing of the relationship and the ratio size of one part to another, e.g. the cervix and the body of the uterus, fallopian tube and ovary etc. The drawing should always be accompanied by explanation. Bulletin boards are valuable teaching aids and should be attractive with gaily coloured cut-outs. Very useful in presenting some topics, e.g. local foods that build strong babies, foods that prevent anaemia, how to protect food and water from dust and flies, etc. Films and filmstrips are valuable to depict situations and procedures that are beyond the presentation by the trainer, e.g. how the baby is born.

These materials can make the learning experience more concrete and memorable when properly used and selected, and within the context of the local culture and level of understanding of the TBA. The trainer should possess a knowledge of the principles as well as the skills involved in their use so as to enhance the teaching-learning process.

5.5 TOTAL PROGRAMME CONTENT OUTLINE

Antepartal care	Intrapartal care	Postpartal care
1. Introduction - Advantages of antepartal care 2. Elements of anatomy and physiology - Female reproductive organs - Male reproductive organs 3. Pregnancy - Conception and growth of the baby - The signs and diagnosis of pregnancy 4. Antepartal period and TBA management - Examination of the pregnant woman - Urine testing	1. Early labour in apparently normal woman and TBA management - Signs of impending labour - Normal changes in the woman as labour progresses - Comfort and support measures - Diet - Examination and preparation of woman in labour 2. Normal delivery and TBA management - Signs of impending delivery - Observation of fetal and maternal condition - Methods of delivery: prevention of perineal laceration	1. Physiological changes during the puerperium 2. Routine care of the mother 3. Minor discomforts of the mother and TBA management - sore nipples - engorged breasts 4. Complications of the puerperium and TBA management - puerperal infections - delayed bleeding - retention of urine - urinary tract infection

Antepartal care	Intrapartal care	Postpartal care
- Diet in pregnancy - Common discomforts during pregnancy - Danger signs during pregnancy - "At risk" clients 5. Advice to the pregnant woman	3. Separation and expulsion of the placenta - Methods of delivering the placenta - Control of bleeding - Examination of the placenta 4. Advice to mothers and family 5. Complications of labour and TBA management - Prolonged labour - Bleeding before the baby is born - Convulsions 6. Complications during delivery and TBA management - Malpresentations - Prolapse of the cord 7. The newborn infant - General care of the newborn infant - High risk infants and infants with deviations from normal. TBA management - Measures to begin mother-infant-family relationships	5. Basic health education of mother/family - hygiene (personal and environmental) - feeding for mother and infant - pregnancy spacing - importance of health check-ups for the mother and her baby - birth registration

TOTAL PROGRAMME CONTENT OUTLINE

Interconceptional care	Infant care	Cooperation of TBA with health service and community
1. Review of reproductive physiology 2. Advantages of pregnancy spacing 3. Methods of contraception 4. Advantages and disadvantages of each method 5. Side effects of IUDs and oral contraceptives and TBA management 6. Problems of infertility 7. Provision of information and health education of couples/families/community 8. Referral procedures	1. Normal child growth and development 2. Physical and emotional needs of infants 3. Infections and disorders commonly associated with childhood and TBA management - Prevention of infections and disorders of infants 4. Basic health education of mother/family - Proper feeding practices - Cleanliness - Prevention and control of communicable disease prevalent locally	1. Role of the TBA as a member of the health team 2. Elementary knowledge of: - Personal and environmental hygiene - Prevention of communicable diseases - Care of infectious patient and how to avoid contamination - Prevention of accidents in the home - First aid in the home 3. Persons and agencies 3.1 How to contact the following persons and agencies

Interconceptional care	Infant care	Cooperation of TBA with health service and community
	- Prevention of accidents in the home - first aid in the home - importance of regular check-ups of infants in the health service	- trainer/supervisor - staff of the nearest health service - health personnel to call in emergencies and those for referral of clients - any local social welfare agency 4. Notification of community health problems 5. Notification of occurrence and results of pregnancy

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Suggested Reading

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6. PREPARATION OF TRAINERS AND SUPERVISORS

6.1 Introduction

Trainers and supervisors of Traditional Birth Attendants should logically be drawn from nursing and midwifery personnel, preferably a public health nurse-midwife, or midwife, assisted by auxiliary personnel. The function of the auxiliary would be to complement and supplement the work of the professional trainer or supervisor. Health personnel from other disciplines may also be included as resource-persons in the development of specific aspects of the programme. The public health nurse or midwife assigned to the programme may have to assume the responsibility for both the training and supervision of Traditional Birth Attendants. For this reason the training programme is directed to both trainers and supervisors.

Taking into consideration the problems that are likely to arise from a programme aimed at changing the Traditional Birth Attendant's cultural habits in maternity and child care, it is essential to set up criteria for the selection of those who are to assume the responsibility for the implementation of such a programme.

6.2 Criteria for the selection of trainers and supervisors

It is suggested that trainers and supervisors should preferably be selected among those nurse-midwives or midwives who:

(a) have previously performed supervisory or teaching functions;

(b) have demonstrated genuine interest in their work. An analysis of their work records may be a good source of information;

(c) have demonstrated ability to get along with their co-workers, to communicate their ideas, and to deal effectively with people from a culture other than their own;

(d) are chronologically and emotionally mature, because age, in traditional cultures, is suggestive of wisdom, respect and confidence. The age of the trainer-supervisor can be a vital factor in the success of the programme;

(e) have broad and current experience in maternal and child health and family planning practices;

(f) have knowledge and understanding of traditional birth practices, as the training and supervision of Traditional Birth Attendants must be related to this field of knowledge at every stage.

In cultures where the conduct of childbirth is exclusively carried out by women, trainers and supervisors should be drawn from the group of female nurse-midwives and midwives.

6.3 Training programme for trainers and supervisors

An important step in designing a training programme for trainers and supervisors is to ascertain their related knowledge and experience. This serves as a basis to determine what additional knowledge and skills they need to acquire to be able to carry out effectively the functions which are expected of them. This may be ascertained by an observation of their performance, review of their academic and service records, questionnaires, etc.

The purpose of the training programme is to bridge the gap that often exists between, on the one hand, the health concepts acquired by trainers and supervisors through their education and practice and, on the other hand, the knowledge, beliefs and traditional birth practices acquired by the Traditional Birth Attendant through life experience. An understanding of the Traditional Birth Attendant and of the people in the community in which she lives and works should be one of the main elements in the training programme. Equally important is the mastery of skills in the use of educational methodology, tools and new approaches that will simplify and make effective the task of training and supervising the Traditional Birth Attendant.

Fundamentally, the training programme:

1. Utilizes anthropological, sociological, psychological and statistical data to develop a construct of life styles, folk medicine, childbearing and childrearing patterns within a community.

2. Utilizes approaches to teaching and supervision which ensure the cooperation and support of the TBA and the community in the implementation of the programme, in accord with its stated objectives.

If additional technical knowledge of some aspects of maternity care and pregnancy spacing is needed, it should be included as part of the training programme for trainers and supervisors, and an additional objective should be formulated.

Objectives

1. Utilizes anthropological, sociological, psychological and statistical data to develop a construct of life styles, folk medicine, childbearing and childrearing patterns within a community.

1.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the trainer/supervisor is able to:	
1. identify the following:	
(a) nature of the physical environment including such parameters as: location of the community (mountains, plains, valleys, coastal, rural, urban); the nature of food production; transportation systems and the level of technological development in the area.	Visits or stays in the community for a period of time sufficient to have ample opportunity to: - observe the mode of adaptation people make to their environment in order to survive.
(b) the social structure of the community.	- identify relationships between and among members of the groups in the community. - identify the role of the kinship group. - identify the position the TBA occupies in the system. - identify the role of the TBA and other traditional practitioners and relationships with clients and health personnel.
(c) prevailing patterns of culture, including the following: - traditional birth practices in the community and beliefs and attitudes inherent in them; - the protective function of the rituals;	Investigates the TBA's beliefs and practices related to maternal and child care (what she knows, what she does and how she does it) including: - rituals related to: - birth - illness - puerperium - menses - care of cord, placenta, etc.

Learning objectives	Learning tasks/skills

- influence of cultural values on the health of mothers and children.	- values attached to food and its use;
	- food patterns:
	  - for adults
	  - during the maternity cycle, especially for pregnant women
	  - infants and children
	- values attached to herb medicines;

2. interpret statistical data or health information in defining risk for maternal/infant morbidity and mortality in the community.	Investigates the views of the TBA and her clients on: - desirable number of children in a family - health personnel - health services Reviews the following rates (if available) - infant mortality - neonatal mortality - postneonatal mortality - maternal mortality - birth and discusses possible conditioning factors of such occurrences.
3. assess divergent priorities for maternal-child health care services in health professionals, TBAs and the community.	Discusses approaches to ensure cooperation and support in the implementation and delivery of safe maternal and child health care.

Note: For the accomplishment of the objective, the assistance of a person knowledgeable in social sciences is invaluable for the correct interpretation of anthropological, sociological and psychological data.

2. Utilizes approaches to teaching and supervision which ensure the cooperation and support of the TBA and the community in the implementation of the training programme, in accordance with its stated objectives.

2.1 Learning objectives and learning tasks/skills.

Learning objectives	Learning tasks/skills
At the end of this section the trainer/supervisor is able to: (a) identify principles of adult teaching-learning;	Explains: - importance of thoroughly involving the TBAs in the construction, development and assessment of their own training programme; - ways of having the TBAs' felt needs met in a personally satisfying and culturally significant way; - importance of pacing the amount and content of information to the learning ability and degree of motor speed of individual TBAs.

Learning objectives	Learning tasks/skills
(b) identify the significance of having as a fundamental point of reference of a programme of training for TBAs, the local body of beliefs and practices associated with the maternity cycle;	Demonstrates by giving concrete examples, ways by which, in planning a programme for TBAs: - unnecessary conflicts with existing cultural patterns might be avoided; - harmful elements of the local cultural complex might be nullified. Delineates current practices which should be combated.
(c) describe teaching methods or techniques appropriate to on-the-job training instruction of an older person with limited or no formal education;	Demonstrates simple teaching techniques (including verbal and non-verbal communication methods) which foster active participation of the TBAs and the personal relationship that should exist between trainer and trainee. Discusses the importance of having modern methods or practices adapted to traditional ones.
(d) identify teaching aids which simplify the understanding of the programme content or make it more significant and enjoyable;	Demonstrates how to produce simple and culturally relevant teaching aids and an illustrated manual for the use of the TBA.
(e) identify principles and techniques of supervision;	Explains: - what is to be supervised - how to supervise - when to supervise (frequency) - where to supervise - elements of supervision
(f) explain administrative aspects of the trainer/supervisor's work, including reporting system and recording system;	Designs a recording and reporting system appropriate to the work and tasks assigned to the TBA.
(g) appraise or effectively participate in the appraisal of the teaching and supervisory programme for TBAs.	Explains steps for assessing the effectiveness of the training programme and how to appraise the permanence or impermanence of learning after the training has been completed.

It is especially important that the trainer-supervisor should be regarded as a colleague, co-worker and facilitator of learning rather than as a teacher or stern controller of the TBA's performance.

6.4 Selection and training of the auxiliary to participate in the training and supervision of Traditional Birth Attendants

The selection of the auxiliary for participating with the nurse-midwife in the training and supervision of Traditional Birth Attendants should receive the same careful consideration given to the selection of the nurse-midwife. Midwifery preparation, including family planning, is essential for the auxiliary if she is to guide and give on-the-job training to Traditional Birth Attendants.

The training of auxiliary personnel is related to the actual function required of them. Their tasks are related to the various settings, or situations, in which they will be working, to what is expected from them when working under supervision and what they may have to do in the absence of such support.

The fact that the auxiliary has been trained in simple tasks and may have been trained and employed in her own area indicates to many that she is in a unique position for assisting Traditional Birth Attendants. However, as remarked by Read, "a warning needs to be given about the widely held idea that local personnel, trained and employed in their own area, will know all about the communities they serve. Such individuals may be aware of certain practices relating to health situations, but they do not as a rule know in any systematic way about the social organization of their own people, nor about their cultural patterns of living..." (pp. 122-123 of reference 4).

An understanding of the people of the local community is as important to the auxiliary as it is for nurse-midwives.

The training programme for auxiliary personnel may therefore be developed along the same lines as proposed above for the preparation of trainers and supervisors. Although the keynote of the training programme should be simplicity, it should be comprehensive enough to enable the auxiliary to deal effectively with the specific tasks she will be assigned in relation to training and supervision of Traditional Birth Attendants. A great deal of time should be allocated to demonstration and practice on how to gain cooperation and teach and guide the Traditional Birth Attendant in real work situations. Wherever possible, the trainers and supervisors should be involved in the selection and training of the auxiliary(ies) who will be her co-worker(s) and assistant(s).

Continuing training systems should be devised to ensure that the knowledge of the auxiliary in the field of maternal and child health and family planning is kept up to date and for the improvement of those skills needed for the performance of her additional functions.

Periodic supervision and evaluation of the performance of the auxiliary by her supervisor are essential for the successful participation of auxiliary personnel in a teaching and supervisory programme for Traditional Birth Attendants.

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7. SUPERVISION

One of the factors responsible for the failure of many training programmes is the lack of adequate supervision.

The organizational study on "Methods of promoting the development of health services" describes supervision as "a continuing process of informing, guiding, instructing, correcting mistakes and putting back on the right track whenever necessary ... Useful as it is when the execution of tasks is entrusted to well-qualified professional grade personnel, supervision is absolutely indispensable when auxiliaries are used".[2] What is said about auxiliary personnel holds true for the Traditional Birth Attendant.

7.1 Organization of supervisory activities within the centrally organized health care system

The provision of a post for a public health nurse-midwife at the central level is of great importance. The functions of the public health nurse-midwife in a maternal and child health and family planning programme involving the participation of the Traditional Birth Attendant may include:

(a) Participating in the collection, analysis and interpretation of data on nursing-midwifery needs and resources, as they relate to the delivery of maternal and child health and family planning services on a countrywide basis.

(b) Participating in the planning, implementation and evaluation of maternal and child health and family planning programmes with particular responsibility for their nursing-midwifery aspects, and giving special emphasis to the needs and problems in those areas beyond the reach of, or insufficiently covered by, the centrally organized system of health care. This should include plans for an educational programme and continuing guidance and supervision for Traditional Birth Attendants and nursing-midwifery personnel who are to assume the responsibility for their training and supervision.

(c) Participating in committees dealing with maternal and child health and family planning services, and serving in an advisory capacity in relation to their nursing-midwifery phases.

(d) Providing continuing field consultation services to the intermediate administrative level on nursing-midwifery needs and utilization of resources with a view to extending the coverage of maternal and child health and family planning services to the entire population, with the involvement of Traditional Birth Attendants.

(e) Participating in the development of standards for nursing-midwifery care to serve as a guide for intermediate and local health services.

(f) Participating in and encouraging special studies, surveys or other investigations which may point out specific ways of influencing the attitudes of Traditional Birth Attendants towards the acceptance of new practices and ways of living, through training and supervision.

Intermediate (State or provincial) level

The major function of nursing-midwifery staff at the intermediate administrative level is to provide assistance to local staff and to establish liaison with the central level. This may include:

(a) Estimating the nursing-midwifery resources available for the supervision of Traditional Birth Attendants.

(b) Participating in the selection of nursing-midwifery personnel to cooperate with the programme of training and supervision of Traditional Birth Attendants.

(c) Identifying the need for, and organizing training programmes and in-service education projects and providing supervisory and consultant services to the above-mentioned personnel.

(d) Assisting in the development of facilities for the training and supervision of Traditional Birth Attendants in communities A, B and C.

(e) Keeping an up-to-date record on Traditional Birth Attendants: number of practising Traditional Birth Attendants, location, number of those who have received training, problems and performance, etc.

(f) Participating in establishing screening and referral systems for prenatal and post-natal clients and for high risk mothers and high risk newborn infants.

(g) Participating in assessing the capability of the health services to meet the needs and demands of the community which may be created by the referrals and/or assistance being sought by Traditional Birth Attendants.

(h) Suggesting measures (within given constraints) to overcome the problems related to the involvement of Traditional Birth Attendants in maternal and child health and family planning.

(i) Participating in assessing the need for, and adequacy of, communications and transport facilities to enable health personnel to carry out on-the-spot supervision of Traditional Birth Attendants and to transport clients referred by Traditional Birth Attendants to the health service.

(j) Participating in the appraisal of the Traditional Birth Attendants' programme and suggesting adaptations as are necessary to meet the conditions and needs of communities A, B or C.

(k) Participating in surveys and studies, as mentioned in (f) under central level.

In some countries the intermediate administrative level (State or provincial) may assign their own nursing-midwifery personnel to local health units as trainers and supervisors of Traditional Birth Attendants in maternal and child health and family planning programmes.

Local level

The responsibility of nursing-midwifery personnel in local health units in relation to the supervision of Traditional Birth Attendants, may include:

(a) Participating in planning and administering the programmes and projects undertaken at the intermediate administrative level.

(b) Participating in the study of the local community: social structure and culture of the community; appraisal of the felt and expressed, as well as the essential, health needs of the local people; identification of those negative and positive elements that affect both the planning and the operation of a supervisory programme for Traditional Birth Attendants.

(c) Identifying, through community authorities, the Traditional Birth Attendants and compiling data on their personal, cultural and work backgrounds.

(d) Establishing and maintaining records of the data collected on Traditional Birth Attendants.

(e) Promoting the local community acceptance and participation in the supervisory programme for Traditional Birth Attendants.

(f) Identifying available means of communication and the possibilities for the establishment of a referral system and of transport for clients of the Traditional Birth Attendants (types A, B and C communities).

(g) Coordinating and supervising the work of Traditional Birth Attendants.

(h) Preparing progress report of Traditional Birth Attendants' services, as this provides an analytical interpretation that is basic for the planning and evaluation of the supervisory programme.

(i) Participating in the appraisal of the Traditional Birth Attendants' programme, introducing modifications as are necessary to meet local conditions and needs.

The resources available in types B and C communities for the development of supervisory activities may include:

- Public health nurses or midwives.
- Auxiliary nursing-midwifery personnel.
- The most capable trained Traditional Birth Attendants in the community.

7.2 Supervisory functions of the public health nurse-midwife or midwife

(a) Assumes work leadership. This involves:

- Planning and scheduling of work objectives, in cooperation with all those involved in the supervisory programme.
- Training, supervising and orienting the auxiliary personnel and trained Traditional Birth Attendants who were selected to participate in the supervision of Traditional Birth Attendants.
- Specifically defining their responsibilities towards the Traditional Birth Attendants.
- Following up on accomplishments in terms of the tasks expected from the auxiliary and trained Traditional Birth Attendants involved in the supervision, and of the Traditional Birth Attendants themselves.
- Holding meetings regularly with the auxiliary and trained Traditional Birth Attendants to discuss problems, needs, and actions to be taken for improved performance.
- Providing technical guidance needed, and making herself available to them.
- Coordinating her work with the work of all other personnel involved in the programme.
- Ensuring the cooperation of community leaders in planning, implementing and evaluating the supervisory programme.
- Reporting developments and problems to the health services.

(b) Develops and maintains acceptable standards of performance by:

- Motivating or promoting the morale of those involved in supervision and of the Traditional Birth Attendants through recognition of good work, expressing sensitivity to their feelings and needs, respect for value systems of the local community, acceptance of their helpful ideas, and judicious handling of their complaints.
- Providing the Traditional Birth Attendant with orientation and on-the-job training.
- Continuously evaluating the Traditional Birth Attendant's performance, as well as the performance of those involved in supervision, as a basis for guiding or redirecting their activities.

(c) Carries out other responsibilities:

- Preparing and maintaining reports and records appropriate to the work.

- Ensuring continuous availability of supplies, equipment, transport and other facilities required for the training, supervision and work of the Traditional Birth Attendant.

7.3 Participation of the auxiliary in the supervisory programme

The successful functioning of auxiliaries, when participating in the supervisory activities of Traditional Birth Attendants is dependent upon the auxiliaries themselves and the professional supervisor. Failure on the part of the auxiliary usually results from inadequate preparation for this additional task, inadequate service facilities, and mainly from the lack of supervision.

The function of the auxiliary in the programme is to assist the professional supervisor in orienting the activities of Traditional Birth Attendants. This may include:

- working closely with the professional supervisor in providing on-the-spot instructions to Traditional Birth Attendants and helping them to realize safe performances.

- clarifying with the professional supervisor causes of success or failure in the Traditional Birth Attendants' performances and possible action for improvement.

- giving the Traditional Birth Attendants additional information on how to cope with specific situations and referring them to the professional supervisor in situations beyond her competence.

- encouraging the Traditional Birth Attendants to refer or accompany certain clients (high-risk mothers and newborn infants, clients manifesting complications, eligible individuals for family planning, and women manifesting side effects of contraceptives) to sources of aid and to notify occurrence and outcomes of pregnancy.

- participating in meetings organized by professional supervisors.

- serving as a link between the Traditional Birth Attendants and the professional supervisor by reporting regularly to the professional supervisor problems and performance of the Traditional Birth Attendants.

- collecting such information as may be pertinent or helpful to the professional supervisor as for example: number of prenatal visits per client; the proportion of clients manifesting complications who were attended by Traditional Birth Attendants.

- providing adequate materials or supplies to the Traditional Birth Attendants; these supplies will include those needed for her own health care, for maintaining personal cleanliness (particularly the washing of clothes and hands), for protection against disease carriers (mosquitos and rodents); for food preparation, and for the performance of her tasks.

7.4 Utilization of the assistance of trained Traditional Birth Attendants in the supervision of their peers

The trained Traditional Birth Attendants may have an important part to play in the development of supervisory activities. The trained Traditional Birth Attendants to be selected should be the ones who are capable of doing the required job and who might be expected to be responsible in carrying out the assigned work.

The purpose of their assistance is to extend the work of the professional supervisor and of the auxiliary so as to reach, with supervision, a greater number of practising Traditional Birth Attendants in the community. They need careful training if they are to make their best contribution to the programme. They should know what the health service is trying to do, how it runs and what kind of activities it carries on, and should be imbued with a sense of belonging to the health service as a voluntary member of it.

Every trained Traditional Birth Attendant participating in the programme should have a clear interpretation of the job to be done, and the extent and limits of her participation. In other words, she should know what to do and how to do it.

The tasks of the trained Traditional Birth Attendant, in the supervision of her peers, may include:

- Checking action undertaken by Traditional Birth Attendants, associated with maternity care, care of the infant and family planning.

- Helping them to realize safe performance, and clearing with the professional supervisor (and, in her absence, with the auxiliary) possible actions for improvements of their practices.

- Assisting the Traditional Birth Attendants in locating community health resources; encouraging them to refer or accompany clients with special needs (high-risk mothers and newborn infants, clients manifesting complications, eligible individuals for family planning, women with side effects of contraceptives, etc.) to the health services and to notify occurrence and outcomes of pregnancy.

- Assisting the Traditional Birth Attendants in preparing midwifery kit supplies for use.

- Participating in and motivating Traditional Birth Attendants to attend meetings and/or refresher training organized by the health services.

- Sharing her experiences with the professional supervisor and auxiliaries through verbal reporting of Traditional Birth Attendants' problems and performance.

The involvement of trained Traditional Birth Attendants in the supervision of the work of their peers has many advantages. It provides recognition and responsibility for trained Traditional Birth Attendants of special ability. They belong to the same cultural group and are likely to have a better understanding of the problems of the Traditional Birth Attendants and to be more readily accepted by them.

Auxiliaries and trained Traditional Birth Attendants involved in the programme should work directly under the supervision of the professional supervisor who serves as the coordinator of the services provided. They work together, with the supervisor maintaining the overall responsibility, while at the same time, giving full recognition to the importance of the contribution of all those involved in the programme.

7.5 Skills needed to perform supervisory functions[1]

Technical competence is essential for the supervisor in understanding and evaluating the work of the Traditional Birth Attendant.

In some countries, there seems to be a tendency to downgrade the need for technical competence in the teaching and supervision of Traditional Birth Attendants. To make a person the teacher and the controller of a work in which she is not proficient leads to failure in the process of teaching and supervision. Technical competence is related to:

(a) Skills in planning and organizing her work in a variety of ways so as to adjust to individual differences and changes in the situations in which the work is carried out. This requires a conceptualization of the ways by which new procedures and tasks will be accepted by the Traditional Birth Attendant, of the setting in which teaching and supervision should take place for better results, of how many other activities can be added to the ones already being performed by the Traditional Birth Attendant, and of how to make the best use of more experienced and capable Traditional Birth Attendants.

(b) Skills in interpersonal relations which relate to the ways the supervisor talks and acts in face-to-face contact with the Traditional Birth Attendant. The Traditional Birth Attendant's willingness to maintain contact with her supervisor and willingness to be influenced depend upon her actual experience with the supervisor, which results in the Traditional Birth Attendant's acceptance or rejection of the supervision.

Mutual understanding is essential for good interpersonal relations and is fostered when the supervisor gives recognition to the role of the Traditional Birth Attendant. She should clarify with the Traditional Birth Attendant where they, as outsiders, stand in relation to the group; explore the expectations of the Traditional Birth Attendant with respect to the style of teaching and supervision which seems most appropriate to her; work with the Traditional Birth Attendant under the same circumstances; listen to what the Traditional Birth Attendant has to say; show sincerity, patience, perseverence and genuine interest in the Traditional Birth Attendant and her work; observe social amenities established in the local culture.

Interpersonal skills and skills in the conceptualization of the work to be done complement each other. By working with the Traditional Birth Attendant and by a real understanding of the way of living of the people in the village community, supervisors can learn what kind of behaviour on their part will bring out the best in the Traditional Birth Attendant.

(c) Skills in guidance and counselling as well as in devising and using teaching methods and tools which are specifically appropriate for Traditional Birth Attendants.

(d) Skills in interpreting aims and plans for the development and improvement of maternal and child health and family planning programmes to the Traditional Birth Attendant, and interpreting the needs and reactions of the Traditional Birth Attendant to the health services. The supervisor serves as a link between the Traditional Birth Attendants and the local community and health services.

The climate the trainers and supervisors establish, the example they set, the quality of performance they require and the recognition system they use have great impact on the performance and morale of the Traditional Birth Attendant.

7.6 Planning for better results

The challenge to provide effective supervision is enhanced by having a well planned supervisory programme. Better results are achieved by:

(a) Work coordination

Preferably one person should be responsible for supervising all activities of the Traditional Birth Attendants in a given area. When supervision is exercised by more than one person, there needs to be close coordination among all those involved in supervisory activities, to avoid conflicting orientation, which may result in non-acceptance of the supervisor's role.

(b) Ratio of Supervisors to Traditional Birth Attendants

The number of the Traditional Birth Attendants to be assigned to a single supervisor should be limited to the number she will be able to see on a regular basis to give adequate attention, guidance and on-the-job reinforcement of their training.

(c) Job description

There should be a clear definition of the Traditional Birth Attendant's responsibilities, based on realistic expectations of her role, according to the circumstances in which she works (A, B or C community) and the training received. The job description may consist of a simple list of the tasks she is expected to perform.

(d) Appraisal of performance

Continuous accurate appraisals based on the methods of assessment described on the training programme must be made by the supervisor.

(e) Recognition

Some form of recognition should be granted to those who are performing well, on the basis of established criteria. Recognition, when adequate, timely and judiciously granted, produces good feelings. However, good feelings that endure are caused by rewards which have a prestige value in the local culture, which will prove to be highly satisfying and therefore stimulate the Traditional Birth Attendant to improve performance (refer to 3.4).

7.7 Sequence in designing a supervisory programme for the Traditional Birth Attendant

Approaches in designing a supervisory programme for Traditional Birth Attendants, in a home or community situation, may be developed in the following sequence:

1. Study of the Traditional Birth Attendant's needs in relation to the tasks she is expected to perform. Visits to work areas for on-the-spot observation of the Traditional Birth Attendant's activities.

2. Study of local educational and other related resources. Exploration and utilization of those resources that may supplement and enhance the work of the supervisor with the Traditional Birth Attendant.

3. Involving community members in cooperative efforts in the planning, implementation and evaluation of the supervisory programme in the community.

4. Preparing the programme outline.

5. Establishing consultative relationships with representatives from other disciplines to help in identifying, analysing and interpreting the needs and problems of Traditional Birth Attendants and in advising on approaches which may prove effective in meeting these needs.

Optimum results, both in terms of performance and in terms of the Traditional Birth Attendant's development, depends on the skills and leadership of the supervisor. Properly used, the supervisor becomes one of the most potent tools for performance improvement.

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8. EVALUATION OF THE PERFORMANCE OF TRAINED TRADITIONAL BIRTH ATTENDANTS WITH REGARD TO MATERNAL AND CHILD HEALTH AND FAMILY PLANNING

The following definition, quoted from the report of a WHO Expert Committee on Family Planning in Health Services, is used in this context: "Evaluation is any systematic process of measuring the efficiency, effectiveness and ultimate impact of a programme starting with defined objectives and using quantitative and qualitative information" (p. 54 of reference 1).

Necessary requirements* to assess the desirability (in terms of effectiveness, efficiency, and acceptability) of a maternal and child health and family planning programme involving the collaboration of the trained Traditional Birth Attendant are:

8.1 A clear statement of the desired outcomes of the programme.

8.2 Collection of information to be used at all levels of health services:

(a) personal data for each Traditional Birth Attendant recruited by the health unit: age, level of formal education, distance of home from the health unit, methods of training, amount of training, level of competence in safe maternity practices.

(b) records of progress made by health units in the recruitment and training of traditional birth attendants: numbers identified, numbers recruited, types and amount of training given, numbers reaching various levels of performance (refer to 5.4).

(c) routine collection and tabulation of data at health units as indicators of maternal and child care and family planning performance for each Traditional Birth Attendant: number of pregnancies and the outcomes (live births, abortions, still births) reported to the health unit; referrals of complications and "high risk" mothers and infants; referral of children for immunization; referrals of eligible individuals/couples to family planning services; characteristics (especially age and parity) of clients referred to family planning services.

In some cases it may be possible to include among measures of performance reduction in maternal mortality as a result of dangerous manoeuvres during labour and reduction of infant mortality from such causes as umbilicus tetanus, birth traumas, etc. Generally it would be very difficult to establish relationships between the performance of Traditional Birth Attendants and changes in maternal and infant morbidity and mortality, as such changes are influenced by many factors (social, economic, and environmental conditions).

It may be assumed that a higher achievement on such record tabulations in relation to maternal and child health and family planning programmes, reflects a higher quality of performance.

8.3 Analysis of performance as a guide to policy decisions on the design and emphasis of the programme

(a) analysis of Traditional Birth Attendants' performance by time, locality, demographic characteristics of the locality, stage of training, trainers'/supervisors' characteristics, Traditional Birth Attendants' characteristics;

(b) special surveys to investigate community reactions to the programme;

(c) determination of the efficiency of the programme that is the relationship between total programme inputs and measurable outputs (quantitative and qualitative).

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* Based on WHO Report of Interregional Meeting on the Training and Utilization of the Traditional Birth Attendant in Maternal and Child Health and Family Planning, Philippines, 2-6 December 1974, pp. 11-12.

8.4 Feedback of the effects of these activities to health units, Traditional Birth Attendants and communities

(a) regular issue of progress summaries to health units. These should be of a kind that will enable the health unit to compare its own performance with that of similar units and analyse factors contributing to or retarding progress;

(b) oral reports to traditional birth attendants on progress in their area and progress of the programmes as a whole;

(c) information to local community by the health unit on progress in their area and progress of the programme as a whole.

Information on progress of the programme in particular areas and as a whole may stimulate a more vigorous cooperation of Traditional Birth Attendants and local communities with the health services.

Where a programme, as organized and developed, has been less effective than expected, alternative courses of action should be selected. The selection of alternative courses of action is a matter for administrative decision. However, criteria used for such decisions should necessarily include the preference and demands of the consumers of those services.

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9. CONCLUSIONS AND PROBLEMS FOR FUTURE INVESTIGATION

1. In rural areas and in depressed sectors of urban centres of many developing countries the role of the traditional Birth Attendant is well recognized. This is due to the relative inaccessibility of trained health personnel and/or simply an indication of the community acceptance of traditional practices.

2. However, the contribution which the traditional birth attendant can give to modern health programmes is not yet fully appreciated. In many countries she has no official recognition and is, in fact, practising outside of the law.

3. The reluctance of many health professionals to take advantage of improvements that can follow from a more effective collaboration between traditional birth attendants and modern maternal and child health programmes apparently arises from the lack of knowledge about traditional systems of health care.

4. Similarly, traditional birth attendants and other traditional practitioners may be reluctant to adopt modern practices which are alien to the way of life of their community.

5. To attain the goal of reducing the risk of illness and deaths to which mothers and children are exposed in areas where the standard of maternity care is low and to extend the coverage of maternal and child health and family planning by encouraging the contribution of traditional birth attendants to these services, the following should be undertaken:

- formulate, within the policy for maternal and child health, plans and means which contemplate the institutionalization of the traditional birth attendant's involvement in health care programmes. These plans should include measures for adequate financial support for the training and utilization of traditional birth attendants as well as measures for the training and deployment of health personnel participating in the programme.

To this end the following should be considered:

- promote regulations governing the practice of traditional birth attendants;

- create courses for the training of personnel who will participate in the programme, preferably in rural areas, to help them understand the life style of the community where the traditional birth attendant lives and works and the rationality of her practice;

- develop a system of continuous or step-by-step training for traditional birth attendants to enable them to become competent and willing to apply safer methods of maternal and child care including help with family planning.

Training programmes should be developed with well defined objectives based on the felt needs of traditional birth attendants and priority needs for improved maternal and child health care and family planning service in a given area. Existing traditional beliefs and practices that contribute positively to the physical and emotional health of the mother and the child should be reinforced, and those that have an adverse effect modified:

- stimulate the production of educational material attuned to local cultures to simplify the teaching or make it more interesting and enjoyable;

- establish an efficient system of supervision based on simple and reliable evaluation methods;

- establish and disseminate technical standards in maternal and child health;

- encourage active community participation in each stage of the programme so as to enhance the status and acceptability of the trained traditional birth attendant in the community;

- establish a system of services to accomplish these tasks based on the principle of multidisciplinary teamwork, including the traditional birth attendant;

- design schemes for assessing the effect of the performance of traditional birth attendants in maternal and child health and family planning against specified criteria for effectiveness, efficiency and acceptability;

- encourage and conduct studies and applied research with a view to using the potentials of the traditional birth attendants more effectively.

Studies are needed in the following areas:

- The social position of the traditional birth attendant in the community where she practices (as a means of determining her potential role as fellow-worker with health personnel and whether she is in a position to influence the people of the community to accept modern methods of maternal and child health care and family planning).

- The community cultural tradition. Traditional beliefs, values and practices associated with pregnancy, childbirth and postpartal care, including dietary habits and traditional herbal remedies (as a means to understand the rationality of traditional birth attendants' behaviour).

- Nature of the conflict between modern and traditional systems of maternity care and family planning. Such studies may point out specific ways of adjusting one culture to another.

- Perception of traditional birth attendants by health professionals and of health professionals by traditional birth attendants.

- Effective methods and approaches to training and retraining for traditional birth attendants, trainers and supervisors.

- Investigations and field trials of various incentives or reward systems which directly encourage traditional birth attendants to apply the new knowledge and practices in maternal and child health and family planning which they learned in the training course.

- Effects of training on the status and acceptability of the traditional birth attendant in the community.

- Effects of practices of untrained and trained traditional birth attendants on maternal and newborn mortality and morbidity.

The satisfactory planning of these studies and the application of their findings require a substantial amount of interdisciplinary cooperation. The involvement of specialists from places where similar programmes have been implemented may also be helpful. Included in this document (Annex IV) is a copy of questionnaire used at the national workshop to review researches into Dukun activities related to maternal and child health care in Djakarta in 1972. It includes questions which are of special significance in providing information for the planning of a programme utilizing the assistance of the traditional birth attendant.

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TITLES USED TO DESIGNATE TRADITIONAL BIRTH ATTENDANTS* - 1972

Title	Country or territory	Region	Remarks
Accoucheuse Traditionelle	Turkey Rwanda	EUR AFR	
Allewa Vuku Ambuya	Fiji Rhodesia	WPR AFR	"Shona" name for grandmother
Babele Xisi	Lesotho	AFR	. . .
Bidan	Malaysia Papua New Guinea	WPR WPR	Also referred to as Kampong Bidan
Bundo Mamy	Sierra Leone	AFR	
Bush Midwife	Mont-Serrat	AMR	Rural midwife
Chaé	Paraguay	AMR	Also referred to as Empirica
Comadrona	Argentina Ecuador Guatemala Mexico Nicaragua Peru Uruguay	AMR	God-mother Also referred to as Partera Empirica (empirical midwife)
Curiosa	Brazil Portugal	AMR EUR	Also referred to as Parteira (midwife) Curiosa (empirical knowledge)
Dada	Yemen	EMR	Also referred to as "daya"
Dai	Afghanistan Bangladesh India Mauritius Pakistan	EMR SEAR SEAR AFR EMR	Also spelt "dayah"
Daya	Egypt Israel Jordan Lebanon Libyan Arab Republic Syrian Arab Republic	EMR " " " " "	Also spelt "dayah" " " " " " " " " " " " " " " "
Djiddah	Iraq	EMR	Arabic word meaning grandmother Also spelt "Jiddah" or Jidda
Dukun-Baji	Indonesia	SEAR	The existence of several kinds of "dukuns" shows a specialization among them: "Dukun pidgats" (massage); "Dukun Sanghai putung" (for broken bones); "Dukun Petungan" (for rice planting); "Dukun-Bajis" (those rendering assistance during childbirth). The dukuns who are not registered are called "dukun liar" meaning "wild dukuns" or "loose dukuns"
Empirica	Bolivia Chile Colombia Costa Rica Dominican Republic El Salvador Honduras Panama	AMR " " " " " " "	Also referred to as "Partera Empirica"
Empirical Midwife	Liberia	AFR	Also referred to as Indigenous Midwife or "Traditional Midwife"

* Sources of reference: unpublished WHO assignment reports on various countries and information collected through a WHO questionnaire (referred to in chapter 2 of this document).

Annex I

TITLES USED TO DESIGNATE TRADITIONAL BIRTH ATTENDANTS - 1972 (continued)

Title	Country or territory	Region	Remarks
Femme Charge	St Lucia	AMR	
Femme Sage	Haiti	AMR	There are also male birth attendants called "homme-sage". The registered trained midwife is called "Sage-femme"
Femme Shi	Grenada	AMR	Also referred to as Bush-Midwife
Fooluma	Maldives	SEAR	
Gidah	Democratic Yemen	EMR	Also spelt "Jidda"
Granny	Nigeria Surinam	AFR AMR	Meaning old woman or grandmother
Gode-Vinappa Amma	Ceylon	SEAR	
Habbaba	Saudi Arabia	EMR	Also referred to as "Mama"
Hilot	Philippines	WPR	Meaning "massage". In some provinces she is referred to as "magpapaanak"
Kabla	Morocco	EUR	
Let-the	Burma	SEAR	
Local Midwife	Dominica	AMR	
Mama	Iran	EMR	
Matrone	Cameroon Chad Dahomey Gabon Ghana Guinea Upper Volta Ivory Coast Kenya	AFR AFR AFR AFR AFR AFR AFR AFR AFR	From Latin "mater" meaning "mother" (the term "matrone" may also signify a young village girl who has received midwifery training)
Matrone	Madagascar Mali Niger Senegal Togo Tunisia Cambodia Laos Viet-Nam	AFR AFR AFR AFR AFR EMR WPR WPR WPR	
Ma'uli	Tonga	WPR	
Moh. Tam. Yae	Thailand	SEAR	
Middy	Trinidad and Tobago	AMR	
Nanny	Barbados Belize Guyana	AMR AMR AMR	Meaning "nursemaid"
Nana	Jamaica	AMR	Meaning "grandmother"
Omolesso	Somalia	EMR	Also spelt "Umilisses"
Partera Tradicional	Spain	EUR	Meaning "traditional midwife". The profession of "Matrona" is a middle level profession and the title of "Matrona" is granted by the Ministry of Education
Recogedora	Cuba	AMR	Meaning "one who catches the baby"
Rope Midwife	Sudan	EMR	Title due to the technique of utilizing a rope during delivery
Sureni	Nepal	SEAR	

Annex I

TITLES USED TO DESIGNATE TRADITIONAL BIRTH ATTENDANTS - 1972 (continued)

Title	Country or territory	Region	Remarks
Traditional Midwife	United Republic of Tanzania	AFR	
Tia Kabung Tofunga	Gilbert Islands Ellice Islands	WPR WPR	
Wata Sitong	Timor	WPR	

ANNEX II

STATISTICAL DATA

TABLE 1. AVAILABLE PERCENTAGE OF DELIVERIES ATTENDED BY DOCTOR OR MIDWIFE*

Country or territory	Year	% of deliveries attended by doctor or midwife	Country or territory	Year	% of deliveries attended by doctor or midwife
Africa			Europe		
Mauritius	1968	63.3	Austria	1967	100.0
São Tomé and Principe	1968	63.5	Bulgaria	1967	100.0
			France	1967	99.4
America			Greece	1968	100.0
Barbados	1968	71.9	Hungary	1965	99.1
Canada	1967	95.4	Monaco	1967	100.0
Colombia	1967	40.5	Netherlands	1967	100.0
Dominican Republic	1968	45.0	Poland	1968	99.5
Panama	1967	61.2	Portugal	1967	63.16
Bermuda	1968	100.0	Romania	1968	97.4
Canal Zone	1968	100.0	Yugoslavia	1967	64.6
Dominica	1968	100.0			
Grenada	1968	100.0	Western Pacific		
Puerto Rico	1968	95.0			
St Kitts and Nevis and Anguilla	1968	86.0	Singapore	1968	81.0
			Cook Islands	1968	94.0
St Lucia	1968	100.0	Macao	1968	99.18
			New Caledonia	1968	68.0
Eastern Mediterranean			Wallis and Futuna	1968	100.0
Cyprus	1968	100.0			

* Off. Rec. Wld Hlth Org., 192.

Annex II

TABLE 2. SUPERVISION OF BIRTHS IN SELECTED COUNTRIES*
(DATA PRIOR TO APRIL 1968)

Country or territory	Percentage of births in hospital or supervised domiciliary	Percentage of all** supervised births
Africa		
Ghana	33	41
Kenya	20	-
Liberia	11	-
Mauritius	58	41
Morocco	10	98
Nigeria (Federal District of Lagos only)	93	91
United Republic of Tanzania	22	96
Tunisia	24	-
Uganda	31	-
Asia		
Afghanistan	-	-
Ceylon	99	65
Hong Kong	95	98
Republic of Korea	-	-
Malaysia	28	-
Nepal	3	33
Singapore	99	76
Thailand	16	56
Turkey	-	-

* Taylor, H. & Berelson, B. (1968) Maternity care and family planning as a world program, Amer. J. Obstet. Gynec., 100(7), 885-893

** Either in hospitals or at home but attended by trained personnel under the direction of the hospital.

- Not available.

Annex II

Country or territory	Percentage of births in hospital or supervised domiciliary	Percentage of all supervised births that occur in hospitals
Latin America		
Barbados	54	100
Chile	74	98
Colombia	33	92
Costa Rica	64	93
El Salvador	16	95
Honduras	20	100
Jamaica	70	55
Peru	28	74
Venezuela	61	95

Median for all reporting countries at 33%. Based on the same Table 2, the percentage of deliveries attended by "Others" which might be presumed to include those attended by Traditional Birth Attendants are shown in Table 3.

Annex II

TABLE 3. PERCENTAGE OF NON-SUPERVISED BIRTHS (PRIOR TO APRIL 1968)

Country or territory	% of births attended by "Others" without supervision
Africa	
Ghana	67
Kenya	80
Liberia	89
Mauritius	42
Morocco	90
Nigeria (Federal District of Lagos only)	7
United Republic of Tanzania	78
Tunisia	76
Uganda	69
Asia	
Afghanistan	-
Ceylon	1
Hong Kong	5
Korea	-
Malaysia	72
Nepal	97
Singapore	1
Thailand	16
Turkey	-
Latin America	
Barbados	46
Chile	26
Colombia	67
Costa Rica	36
El Salvador	84
Honduras	80
Jamaica	30
Peru	72
Venezuela	39

Median for all non-supervised births in developing countries - 67%.

Annex II

TABLE 4. PERCENTAGE OF DELIVERIES OCCURRING IN ALL GOVERNMENT MEDICAL ESTABLISHMENTS AND HOME DELIVERIES PROFESSIONALLY ATTENDED BY GOVERNMENT MEDICAL PERSONNEL FOR SELECTED COUNTRIES*

Country or territory	Year	% of deliveries occurring in all government medical establishments	% of home deliveries professionally attended by government medical personnel	% of deliveries attended by others
EURO				
Morocco	1970	(a) 9.2	-	-
Turkey	1970	(a) 7.3	-	-
SEARO				
Burma	1969	(a) 6.8	-	-
WPRO				
Brunei	1970	(a) 26.3	51.8	21.9
Fiji	1970	68.4	11.4	2.2
Gilbert and Ellice Islands	1970	(a) 45.8	42.8	11.4
Cambodia	1970	(a) 5.7	6.3	88.0
Laos	1970	(a) 3.9	-	-
Malaysia:				
East Malaysia (Sarawak)	1970	(a) 35.3	56.0	8.9
West Malaysia	1969	37.4	23.6	39.0
New Caledonia	1970	(a) 73.0	0.4	26.6
Polynesia (French)	1970	(a) 64.0	-	-
Singapore	1970	76.2	-	-
Western Samoa	1970	42.3	-	-
AFRO				
Central African Republic	1969	(a) 25.6	1.7	73.0
Liberia	1969	(a) 27.3	24.6	51.9
Mauritius	1970	28.2	25.8	54.0
Senegal	1969	(a) 39.2	20.8	40.0
Spanish Sahara	1970	51.5	10.0	38.5
Uganda	1970	(a) 51.9	0.8	47.3
EMRO				
Cyprus	1970	31.9	2.2	65.9
Kuwait	1970	68.4	23.8	7.8
Libyan Arab Republic	1970	(a) 22.7	3.7	73.6
AMRO				
Antigua	1971	76.0	16.5	7.5
Barbados	1970	79.4	8.3	12.3
Colombia	1970	41.7	5.4	52.9
Costa Rica	1971	76.1	-	-
Cuba	1970	93.7	-	-
Dominican Republic	1970	47.2	-	-
El Salvador	1970	29.6	-	-
Haiti	1970	(a) 10.1	-	-
Honduras	1970	12.6	-	-
Jamaica	1970	46.7	22.1	31.2
Paraguay	1970	22.5	1.4	76.1
St Kitts and Nevis	1970	(a) 54.2	38.2	76.0
Venezuela	1971	50.6	6.2	43.2

* Table based on data collected in 1971 through a WHO questionnaire.

(a) Percentage calculated on the basis of estimated number of live births.

Annex II

TABLE 5. ESTIMATED PERCENTAGES OF DELIVERIES ATTENDED BY TRADITIONAL BIRTH ATTENDANTS AND BY UNTRAINED PERSONS

Region	Country	Year	Estimated % of domiciliary deliveries attended by		Reference***
			Untrained persons*	Traditional birth attendants	
AFR	Chad	1961	98.5		(3)
	Ghana	1970		75	(2)
	Kenya	1972		80-90	(15)
	Malawi	1961	98.0		(3)
	Mauritania	1961	50.0**		(3)
	Tanzania	1972		60 (and over)	(17)
	Togo	1972		50	(16)
	Uganda	1972		70-80	(12)
	Upper Volta	1961	99.3		(3)
AMR	Chile	1961	89.0		(3)
	Ecuador	1970	71.4		(1)
	El Salvador	1961	46.2		(3)
	Paraguay	1972		70	(18)
EMR	Egypt	1971	50.0		(6)
	Iran	1971		60	(5)
	Iraq	1972		80 (and over)	(13)
EUR	Portugal	1961	69.2		(3)
	Yugoslavia	1961	83.5		(3)
SEAR	Indonesia	1971		80-90	(4)
	Nepal	1968	90.0		(7)
	Thailand	1972		75	(19)
WPR	Republic of Korea	1963	94.0 (rural) 50.8 (urban)		(10)
	Malaysia	1969		50 (rural)	(11)
	Philippines	1972		48	(14)
	Tonga	1970		50	(9)
	Western Samoa	1970		70 (rural)	(8)

* Untrained persons include traditional birth attendants, family members, neighbours.

** Of registered births, total number of births unknown.

*** See reference at the end of Table 5.

The data provided in all these tables may give some idea of the births occurring in institutionalized services or at home by trained and untrained attendants. However, studies of the data on the same country taken from different official sources show, in many instances, wide discrepancies. It is therefore presumptuous to use these data as indicator of the involvement of the traditional birth attendant in the maternity care in many countries.

Annex II

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ANALYSIS OF EXISTING TRAINING PROGRAMMES FOR TRADITIONAL BIRTH ATTENDANTS: INFORMATION RECEIVED IN 1972 FROM TWENTY SOURCES

I. TRADITIONAL BIRTH ATTENDANTS' TRAINING PROGRAMMES - GENERAL INFORMATION

Country, territory or source	Length of the programme	Some admission requirements				Teaching staff					Practical experience under supervision				Programme (year)
		Practising traditional birth attendant	Village member	Age	Level of general education	M.D.	R.N.	Nurse midwife	Midwife	Others (specify)	Hospital and maternities	centres	Home	Others	Formulation (year)
AFRO															
Central African Republic	3 weeks	✓	✓	-	-	-	-	-	-	Auxiliary midwife WHO and USAID staff	✓	-	-	Maternal and Child Health Centres Dispensaries	1972
Togo	18-24 mths	-	✓	18-20	Elementary Sch. Certif.	-	-	-	✓	-	✓	-	-	-	-
AMRO															
Belize	6 months	✓	✓	-	Read & write	-	-	-	✓	Public Health services staff	✓	-	✓	-	-
Costa Rica	1 month 80 hours	✓	✓	21-60	Read & write	✓	✓		-	Sanitary inspector	-	-	✓	-	-
Dominican Republic	4 months	✓	✓	-	-	✓	✓	-	-	Auxiliary nurses	-	-	✓	-	-
El Salvador	✓	✓	✓	-	-	✓	✓			Nutritionist Social worker	-	-	✓	-	-
Guatemala	106-250 lessons	✓	✓	20-60	Read & write	-	✓	-	-	-	-	-	✓	-	-
Honduras	10 sessions	-	-	-	-	-	-	✓	✓	-	✓	-	✓	Health Centre	-
Nicaragua	4-6 weeks	✓	✓	-	Read & write	-	✓	✓	-	Auxiliary nurse	-	-	✓	-	-
Panama	-	✓	✓	21 and over	Read & write	-	-	-	-	-	-	-	-	-	-
Paraguay	-	-	-	-	-	-	✓	-	✓	-	-	-	-	Health Centre	-
EMRO															
Iran	6 months	-	✓	18 and over	Elementary Sch. Certif.	-	-	✓	✓	-	✓	-	-	Health Centre	1972
Jordan	-	-	-	-	-	-	-	-	-	-	✓		✓	-	-
Pakistan	1 year	✓	✓	20 and over	-	✓			✓	Health visitor	✓	-	✓	Maternal and child welfare	-
Yemen	2-3 mths	✓	✓	-	Read & write preferably	-	-	-	-	-	-	-	-	Health Centre	1971
UNRWA	-	✓	UNRWA camps	-	Elementary Sch. Certif.	✓	✓	-	✓	-	-	-	✓	-	-
SEARO															
Indonesia	1 year	✓	✓	-	-	-	-	✓	✓	-	-	✓	✓	Maternity Centre	1971
WPRO															
Malaysia*	3 weeks	✓	✓	Up to 60	-	✓	-	✓	-	Other members of Fam. Plan. Board	-	✓	-	Health Centre	1972
Philippines	12 lessons	✓	✓	40-60	-	-	-	-	✓		-	-	✓	-	1971
Tonga	12 lessons												✓	Maternal and Child Health Centre. Dispensary	

* Only training programmes in family planning were received.

Annex III

II. TRADITIONAL BIRTH ATTENDANTS - SUBJECTS INCLUDED IN TRAINING PROGRAMMES

Country, territory or source	General subjects re. maternity care: Anatomy - physiology of reproductive system	Germ theory: disinfection - sterilization	Communicable diseases - immunizations	Preparation and care of equipment and materials	Personal and environmental hygiene	Nutrition - mother, new-born infant	Referral of clients (mother, baby) to health agencies	Health education	Family planning	Registration and notification of births and deaths	Records and reports - (preparation of)	First Aid	Home visits	When to call for professional aid	Pre-natal care: Importance of pre-natal care - Pre-natal clinic	Signs and symptoms of pregnancy	Physical examination*	Urine testing	Recognition and handling of minor disorders	Recognition and handling of complications	Labour: Signs of labour	Management of labour	Recognition and handling of complications	Post-natal Care: Post-natal care	Recognition and handling of minor disorders and complications	Importance of post-natal examinations	Care of new-born: Examination and general care	Recognition and handling of minor disorders	Recognition and handling of complications	Care of premature baby
AFRO																														
Central African Republic	✓			✓	✓	✓	✓				✓					✓					✓			✓		✓	✓			
Sierra Leone	✓			✓	✓	✓	✓			✓			✓			✓	✓			✓	✓			✓	✓		✓			
Togo	✓		✓	✓	✓	✓	✓	✓																						
AMRO																														
Belize	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Costa Rica	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dominican Republic	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
El Salvador	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Guatemala	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Honduras	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nicaragua	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Paraguay	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
EMRO																														
Iran	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jordan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pakistan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Yemen	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
UNRWA	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SEARO																														
Indonesia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
WPRO																														
Korea	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Malaysia	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Philippines	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tonga	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
TOTAL	15	10	11	20		15	12	5	5	12	8	4	5	13	12	13	6	3	12	11	11	19	11	15	10	3	17	9	4	6

* Physical examination includes: examination of face, breast, limbs, inspection, palpation and auscultation of the abdomen, and examination of the vulva.

Remarks:

Several programmes, mainly in the countries of the American Region, specify actions not to be taken by traditional birth attendants such as: "not to render midwifery services in the presence of loss of blood or haemorrhage during pregnancy; when the arm is delivered first", etc. Some of the don'ts for traditional birth attendants also include: "not to introduce the fingers or any instruments or objects in the birth canal of the mother with the purpose of performing examination or any other reasons, not to give injections in the birth canal", etc.

Most of the programmes did not include the dates of formulation, implementation and revision. Although they were received in 1972 they may refer to an earlier date. If this assumption is correct, it may explain the lack of emphasis on family planning. Only five programmes make reference to this subject.

ANNEX IV

QUESTIONNAIRE USED AT THE NATIONAL WORKSHOP (JAKARTA 1972) TO REVIEW RESEARCH INTO DUKUN ACTIVITIES RELATED TO MATERNAL AND CHILD HEALTH CARE AND FAMILY PLANNING

A. The role and status of Dukun in the community*

1. In what ceremonies does the Dukun participate in relation to childbirth?

   (i) Hair cutting
   (ii) Circumcision

2. What methods of pre- and post-natal care does the Dukun provide?

3. What family ceremonies does the Dukun usually attend?

4. How do people in the community acknowledge the status of the Dukun?

   (i) Birthday gift
   (ii) Invitations to festivals

5. How do attitudes towards the Dukun vary between different social groups?

   (i) Educational differentials
   (ii) Religious differentials
   (iii) Regional differentials

6. How much does the Dukun charge for her midwifery service?

7. How many deliveries does she average per month?

8. On what occasions other than childbirth do people consult the Dukun?

   (i) Prophecy

B. Influences on the Dukun's perception of appropriate behaviour with respect to (a) referrals and (b) attempts to influence family size intentions*

1. Who can exert most influence to change the Dukun's behaviour?

   (i) Religious leaders
   (ii) Formal leaders
   (iii) Other Dukuns
   (iv) The MCH Centre

2. What innovations in rewards available to Dukuns most affect their behaviour?

   (i) Financial incentives
   (ii) Gift
   (iii) Esteem for achieving community benefits
   (iv) Approval of MCH staff

* Indonesia Planned Parenthood Association (1972) A Report on Study of Dukuns in Two Central Javanese Communities. Jakarta. (Preliminary report).

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C. Attitudes to family planning and to assistance with the programme*

1. What traditional methods of birth control are recommended or supplied by the Dukun?

(i) Abstinence
(ii) Herbs
(iii) Massage
(iv) Abortion

2. What are her views on the merits of traditional methods?

(i) Effective/not effective
(ii) Acceptable to wife
(iii) Acceptable to husband

3. What does the untrained Dukun know about human reproduction?

4. Does the Dukun find it easy to discuss family planning with people?

(i) With men
(ii) With women

5. What are her views on modern contraceptives?

(i) More effective/less effective than traditional methods
(ii) As acceptable/not as acceptable as traditional method (a) to wife (b) to husband
(iii) Worth/not worth the trouble of visit to MCH Centre
(iv) Natural/not natural

6. Does the Dukun believe that inserting IUD's after delivery is incompatible with cultural restrictions on behaviour immediately after birth?

(i) With respect to a taboo on appearing in public
(ii) With respect to a taboo on intercourse

7. Does she believe that where there is a conflict of view, people should accept her judgement rather than the authority of others?

8. What are her views on the policies and procedures of the family planning programme?

(i) Training procedure
(ii) Postpartum policy
(iii) Relationship with field worker
(iv) Individual incentives
(v) Community incentives
(vi) Involvement of informal leaders
(vii) Possibility that practice of birth control will reduce her work/income

9. Does she believe that however many children people have, the Lord will provide for them?

10. How does the Dukun explain why some women become acceptors?

(i) They are selfish
(ii) They do not like children

* Simons, J. Summary of an attitude study of Dukuns in Central Java, mimeo IPPA. 1972.

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(iii) They want to have an easier life
(iv) They cannot afford food for more children
(v) The husband is indifferent to the needs of the family
(vi) The Lurah is in favour of family planning
(vii) The Dukun persuades them
(viii) Women with small families are envied

11. How does the Dukun explain why some women refuse to become acceptors?

(i) They are frightened by the idea
(ii) They love children
(iii) They want more children
(iv) They do not have a son
(v) They believe large families are happier
(vi) They want children as a future source of income
(vii) The husband will not allow the wife to be an acceptor
(viii) Some of the children may die
(ix) Women with many children are well respected
(x) Women with few children are regarded unfavourably
(xi) Modern methods of birth control are unnatural
(xii) God prefers people to have large families
(xiii) They cannot afford transportation to the MCH Centre
(xiv) They prefer traditional methods

12. What are the Dukun's views on marriage and family building?

(i) Age of marriage - before 17/later
(ii) First pregnancy soon after marriage/deferred
(iii) Spacing between birth - short/long intervals
(iv) Appropriate family size
(v) Relative importance of sons/daughters
(vi) Wife's preferences versus husband's preferences - which to prevail

13. How does the Dukun explain why some Dukuns bring many women to the clinic while others bring few?

(i) In some villages the Lurah helps but not in others (when he helps, how does he help?)
(ii) Some villages are far from the MCH Centres, so that it is difficult for mothers and Dukuns to attend
(iii) Irregular incentive payments

D. Training*

1. What proportion of Dukuns have received a course in widwifery at an MCH centre?

2. What proportion of midwives have received a course in family planning at an MCH centre?

3. What have been the goals of any special family planning training programmes in terms of (a) knowledge and (b) desire to help and (c) understanding of the relationship between family planning and maternal health. (Please attach or refer to printed syllabus if available.)

4. What arrangements have been made for training?

(i) Residential course

* Poerwodihardjo, S. Participation and Training of Dukun in Family Planning. IPPA, b description and syllabus. Ryder, B. and Djuwarini, S., Memorandum of 30 May 1972.

(ii) Weekly session
(iii) Other courses

5. What arrangement seems best?

6. Who conducts the training?

7. In what respect does the training appear adequate/inadequate?

(i) Literacy problem
(ii) Loss of income while attending training
(iii) Reluctance to attend training sessions
(iv) Selection problems

8. How might inadequacies be overcome?

9. Should refresher courses be given after basic training? At what interval?

10. Should subjects such as home economics be included in the Dukun's training?

11. Should the Dukun receive a certificate or other acknowledgement (e.g. a Dukun kit) on completion of training? (Why?)

12. What steps can be taken to increase the number of Dukuns who are registered with an MCH Centre?

13. Why do some Dukuns decline to be trained?

(i) Indifference/hostility
(ii) Believe they already possess sufficient knowledge and skill
(iii) Lack of funds to attend training
(iv) MCH Centre too far from home

14. What can be done to encourage more Dukuns to be trained?

(i) Incentives
(ii) Clothing
(iii) Make them Government employees

15. Are there enough qualified trainers to support training plans?

16. Is it necessary to give Dukuns special training?

E. Relation with health personnel and other family planning workers

1. Who is responsible for supervising the work of the Dukun?

(i) Bidan
(ii) Nurse
(iii) FP FW

2. What difficulties have arisen in the working relationships between health personnel and Dukuns?

(i) Rivalries
(ii) Record problems
(iii) Supervision problems

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3. How might the problems be overcome?

4. What should be the professional relationship between the Dukun and other MCH staff?

5. Should the Dukuns be regarded as employees of the MCH centre?

F. The Dukun's performance as family planning worker*

1. What types of help have been sought from the Dukun?

(i) Postpartum referral
(ii) Other referral
(iii) Give information about family planning services
(iv) Delivery of simple methods
(v) Persuasion of couple to space and limit birth
(vi) Report and counter rumours
(vii) Arrange treatment of side-effects
(viii) Enumerate births

2. How has the Dukun performance been analysed?

(i) By number of referrals, postpartum/other
(ii) By family size of client and other characteristics on clinic record
(iii) Client's persistence with a method
(iv) By sale of contraceptives
(v) By education of Dukun
(vi) By fertility of Dukun
(vii) By number of eligible women in village

3. What record system has been used to record performance of Dukun?

4. What results have been achieved by Dukuns?

(i) Acceptors
(ii) Postpartum referrals
(iii) Other referrals

5. Have the results for trained Dukuns differed from those for untrained Dukuns?

6. Why have referral rates declined?

7. How has performance varied over time?

8. What difficulties have been encountered?

(i) Indifference of Dukuns
(ii) Absence of female doctors

9. What steps could be taken to overcome the difficulties?

* Sampurno and Talogo, R. W. (1972) Survey on Dukun Baji characteristics and Soemodinoto, S. (1972) Dukun as referrer of Family Planning acceptors, a study in East Java, a preliminary report, National Institute of Public Health, Surabaja.

G. Strategy*

1. What problems in the use of Dukuns can be attributed to the current stracegy for their use?

(i) Distance of health centres from village
(ii) Limitation in influence of health centre on Dukun's behaviour

2. What steps might be taken to eliminate the problems, or some of them?

3. What experience has been gained with different strategies?

(i) involvement of formal leaders

4. What can be said for and against a strategy which made the family planning activities of the Dukun the direct responsibility of formal leaders?

5. Should incentives be paid to trained as well as untrained Dukuns?

6. What can be done to eliminate delays in making incentive/transportation payments?

* Simons, J. (1972) Notes on the possible role of community leaders in the family planning programme.

ANNEX V

SUGGESTED TASKS OF THE TRAINED TRADITIONAL BIRTH ATTENDANT WORKING IN COLLABORATION WITH THE HEALTH ESTABLISHMENT[1]

I. Care during pregnancy

1. Detect pregnancies in her area of influence.

2. Refer to the health establishment:[2]

- pregnant women for diagnosis and periodic check-ups, with emphasis on high risk cases: women under 20, women over 35, primigravidae, grand multiparae and women with histories of pathological pregnancies or childbirth;

- pregnant women with possible abnormalities.

3. Keep watch on pregnant women who are apparently normal.

4. Detect signs and symptoms of complications of pregnancy: oedema, headache, blurred vision, persistent vomiting, vaginal haemorrhage and abnormal secretions.

5. Accompany pregnant women to the health establishment when necessary.

6. Supervise pregnant women with problems in accordance with the instructions of the health establishment or her supervisor.

7. Provide guidance on:

(a) importance of prenatal check-ups;
(b) hygiene of pregnancy;
(c) probable date of delivery;
(d) how to obtain help in good time in the event of vaginal bleeding; what to do until help is available;
(e) how to prevent infectious diseases;
(f) nutrition:

- promote the production, storage and preparation of foodstuffs of high nutritional value and give guidance on their appropriate consumption;

- use of food supplements; powdered milk, mixed vegetables, iron, vitamin A, folic acid, etc.

(g) detection of signs of malnutrition;
(h) preparations for childbirth;
(i) selection of the most suitable place for delivery care;
(j) preparations for the care of the newborn child;
(k) postpartum care;
(l) family planning;
(m) importance of the administration of tetanus toxoid.

8. Aid in prevention of infection:

- prevention of infections in the event of miscarriage;

- prevention of infections in the event of premature rupture of the amniotic sac.

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[1] Prepared by the participants of the Interregional Seminar on the Training and Utilization of Traditional Birth Attendants in Maternal and Child Health held in El Salvador, San Salvador, 29 September - 5 October, 1974, including modifications suggested by participants of the Interregional Meeting on the same subject held in Quezon City, Philippines, 2-6 December, 1974. It is suggested that adaptations be made within the framework of local culture and health care systems.

[2] Health establishment refers to the health service(s) which has/have been designated referral point(s) for the area in which the TBA serves.

9. Collaborate with the health establishment in the observation of pregnant women under supervision.

10. Provide information on the hours of work and services of the health establishment and other institutions.

11. Encourage clients to attend pre-natal classes where available.

II. Care during childbirth

1. Recognize the signs and symptoms indicating the start of labour.

2. Prepare the premises and herself for delivery care:

   (a) herself: wash hands, put on gown or apron;

   (b) the house: the site of childbirth and the equipment required for the care of the mother and the newborn child;

   (c) the mother: bath, at least partial, enema if necessary and possible, soaping and washing of the perineal area, bland diet, emotional support, determination of the position of the fetus by careful palpation of the mother's abdomen and assessment of fetal movements, showing the mother how to breathe during labour.

3. Watch for symptoms and signs that childbirth is proceeding normally.

4. Recognize the danger signs during labour and childbirth.

5. Refer and/or accompany to the health establishment any woman with possible abnormalities detected when determining: the position of the fetus; the intensity, duration and interval of the uterine contractions; other danger signs occurring during labour (premature rupture of the amniotic sac, infection of the amniotic fluid, meconium stained amniotic fluid, haemorrhage, prolapse of the umbilical cord).

6. Assist with normal childbirth in a safe and hygienic manner:

   (a) protection of the perineum to prevent tearing;

   (b) prevention of haemorrhage: avoid unsuitable manipulations and medications, inspect the placenta, examine the external genitals, check the hardness of the uterus, place the child at the breast to stimulate uterine contractions;

   (c) clean the mother and change her clothes;

   (d) offer food and drink.

7. Wash and prepare the equipment for the next delivery.

8. Inform the health establishment of the delivery attended and the results.

III. Immediate care of the newborn child

1. Remove secretions from the mouth and nose to prevent asphyxia.

2. Apply simple resuscitation technique, when needed.

3. Dry immediately and wrap in pre-warmed cloth.

4. Prevent infections:

   (a) care of the eyes;

   (b) make a clean and safe ligature of the umbilical cord.

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5. Care for the umbilical stump.

6. Take safe measures to prevent chills (avoid immediate baths usually for at least eight hours).

7. Examine the newborn for any abnormality.

IV. Postpartum care

1. Recognize the normal changes occurring in the postpartum period.

2. Observe the involution, height of the fundus, sensitivity and consistency of the uterus.

3. Observe the lochia: odour, quantity, colour.

4. Observe the breasts and advise the mother on swellings, fissures, colostrum and presence of maternal milk, cleanliness.

5. Examine the external genitals: condition of the tissues (perineum - observe for bruising and oedema), cleanliness.

6. Recognize the signs and symptoms of complications in the postpartum period and the action to be taken:

- puerperal infection;
- delayed haemorrhage;
- urinary retention;
- urinary tract infection.

7. Observe the general condition of the mother.

8. Refer to the health establishment:

- postpartum cases for check-up;
- postpartum cases with suspected abnormality;
- postpartum cases desiring family planning.

9. Provide guidance on:

(a) hygiene of hands, breasts, genitals and body;

(b) hygiene of the home and surrounding area;

(c) nutrition;

(d) appropriate activity/exercise;

(e) danger signs;

(f) sexual relations of the couple;

(g) registration of birth;

(h) importance of breast-feeding for the child and the mother;

(i) onset of menstruation after childbirth;

(j) postpartum check-up in the health establishment;

(k) importance of subsequent check-up for early detection of cancer;

(1) family planning:

- relationship between the first postpartum menstruation and possible fertilization;
- benefits of spacing pregnancies;
- importance of periodic check-ups in health establishments for users of IUDs and contraceptive pills;
- common side-effects of no significance but which require reassurance.

V. Inter-conceptional responsibility

1. Guide and encourage the community in the use of methods for spacing pregnancies (in conformity with the policy of each country).

2. Identify people wishing to plan their families and refer them to the health establishment.

3. Visit and encourage people not attending the clinic for family planning check-ups.

4. Guide the mother on:

- importance of periodic check-ups in health establishments for users of IUDs and contraceptive pills;
- common side-effects of no significance but which require reassurance.

5. Participate with members of the health team and community leaders in talks with couples and groups.

6. Refer users with significant side-effects to the health establishment.

7. Counteract and/or inform the staff of the health establishment of any unfavourable rumour that might undermine family planning.

8. Distribute non-clinical contraceptives (condoms, foams, etc.) and provide instructions on proper use.

VI. After care of the newborn child

1. Provide the mother with guidance on:

(a) characteristics of the normal newborn child;

(b) washing hands before attending to the child;

(c) bathing and cleanliness of the child;

(d) care of the umbilical stump;

(e) feeding the child, with emphasis on breast-feeding;

(f) importance of health check-ups for the child;

(g) how to recognize signs and symptoms indicating complications in the newborn child, and how to have the child referred to the health establishment in the event of fever, alteration in skin colour, dehydration, difficulty in breathing, diarrhoea, changes in umbilical stump with regard to smell, colour and secretions, constipation, urinary retention, difficulty in sucking, restlessness.

2. Refer the newborn child to the health establishment for a check-up at an early stage.

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VII. Care of the child under one year of age

1. Refer children under one year of age for check-ups in the health establishment.

2. Detect malnourished children and children with pathological signs or symptoms (fevers, convulsions, respiratory difficulty, diarrhoea and vomiting). Refer malnourished children and children with pathological signs and symptoms to the health establishment. Follow up the recommendations of the health personnel.

3. Guide the mother on:

   (a) importance of regular check-ups;

   (b) nutrition: prolonged breast-feeding, introduction of supplementary foodstuffs, hygienic preparation of food;

   (c) importance of vaccinations and immunizations;

   (d) measures for the prevention of diarrhoea, and initial treatment;

   (e) prevention of accidents in the home;

   (f) importance of having illness of the child attended to at an early stage;

   (g) importance of home environment conducive to healthy living.

VIII. Coordination of the activities of the traditional birth attendant with the health personnel and the community

1. Inform the community of the services provided by the health establishment.

2. Promote the use of the health and other services in the community.

3. Inform the staff of the health establishment of community health problems.

4. Inform the staff of the health establishment of her activities as appropriate.

5. Attend meetings arranged by the health establishment.

GUIDE TO DETERMINE THE ELEMENTS OF THE INFRASTRUCTURE NEEDED FOR THE TRAINING AND UTILIZATION OF THE TRADITIONAL BIRTH ATTENDANT IN MATERNAL AND CHILD HEALTH CARE AND FAMILY PLANNING SERVICES*

Activities involved in the components of the programme \ Elements	INFRASTRUCTURE: ORGANIZATION AND ADMINISTRATION																																	RESOURCES																									
	Planning and Programming				Organization															Legisl. and Regulations			Information System					Evaluation and Control						Human						Material														Financial					
						NORMS								Manuals			Coordination							Records				Supervision												Expendable							Installations				Equipment								
	Diagnosis of the situation	Policies and strategies	Objectives and targets	Plans and programmes	Administrative structure	Administrative	Technical	Cooperative	Definition of tasks	Delimitation of geographic area	System of interviews and control	Referral system	Logistic system	Administrative	Procedures	Guides	Intra and extra sectoral	Intra and extra institutional	With the community	Sectoral legislation	Nurse/Midwife legislation	Regulations	Statistical and inform. services	TBA	Training given	Mothers and children attended	Cards/Files	Supervisory system	Functional structure	Control of activities	Continuous training	Indicators for evaluation of results	Mechanism of readjustment	TBA	Trained auxiliary personnel	Nurse	Midwife	Physician	Others	Material (basic)	Educational materials	Electricity, water, etc.	Midwifery kit	Material for use of the TBA	Printed material	Office and cleaning materials	Health establishment	Homes	Community	Hostel	Audio-visual	Furniture	Transport	Material and equipment	Maintenance	Incentives	Personnel services	Transportation	Travel expenses
Activities involved in the training of TBAs																																																											
1. To study the maternal and child health situation																																																											
1.1 Identify the problems																																																											
1.2 Identify cultural variables																																																											
2. To promote the interest of the authorities and the community in the plan for training																																																											
3. To plan and programme the training																																																											
4. To provide resources																																																											
4.1 Funds																																																											
4.2 Human (trained health personnel)																																																											
4.3 Physical and material																																																											
5. To undertake the following preliminary actions:																																																											
5.1 Survey of TBAs in the area																																																											
5.2 Maintain a record of TBAs of the area																																																											
5.3 Motivate TBAs to accept training																																																											
5.4 Select TBAs for the training course																																																											
6. To design the training programme																																																											
6.1 Clearly state its objectives																																																											
6.2 Formulate its contents																																																											
6.3 Select an appropriate educational methodology																																																											
6.4 Build-in evaluation techniques																																																											
7. To implement the training programme																																																											
7.1 Assess the training programme																																																											
7.2 Make necessary adjustment on the basis of the results of the evaluation																																																											
8. To formulate and implement a follow-up plan for trained TBAs																																																											
Activities involved in the utilization of the trained TBA																																																											
1. To maintain an up-to-date record of trained TBAs at the health establishment																																																											
2. To award an identification card to the trained TBA																																																											
3. To incorporate the trained TBA as a collaborator of the health establishment																																																											
4. To delimit the geographical area of work of the trained TBA																																																											
5. To provide equipment and material for the work of the trained TBA																																																											
6. To maintain a record of mothers and children attended by the trained TBA																																																											
7. To maintain a record of the activities of the trained TBA and to include the information within the records of the health establishment																																																											
8. To implement the plan of supervision and control of the activities of the trained TBA including:																																																											
8.1 a system of continuous training																																																											
8.2 continuous assessment of the trained TBA performance																																																											
8.3 appropriate guidance based on the results of the evaluation																																																											

*PAHO/WHO (1975) Report of the seminar on the training and utilization of the traditional birth attendant in maternal and child health and family planning, El Salvador, 29 September - 5 October 1974 (page 17) (Original Spanish).

Objective of the "matrix-model"

The objective of the "matrix-model" is to assist in the preparation of an inventory of the elements of the infrastructure (horizontal column, at the head of the matrix) on which corresponding action is needed, when confronted with each one of the activities inferred from the two components - training and utilization (vertical column).

Steps to be followed:

1. Relate the activities listed in the vertical column, point by point, with each one of the appropriate elements of the horizontal column. Place a check (√) in the corresponding square when some action is required, so that the necessary provision is made in each given element to accomplish the related activity.
2. List all the elements checked against the related activities and programme the respective needed actions.

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