Traditional Birth Attendants

A Joint WHO/UNFPA/UNICEF Statement

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Preface

Throughout the world each year, nearly 13 million children die before their fifth birthday. In addition, every year 500 000 women die as a consequence of pregnancy and childbirth. With current technology, the majority of these deaths could be prevented. Furthermore, maternal and child morbidity could be substantially reduced.

The numbers in themselves are immense. However, mere numbers do not convey the personal tragedy visited upon each family that loses a member. A child's death represents the loss of hopes and dreams. A mother's death means the loss of the primary nurturer and often the main producer of the family. Her death will greatly increase the likelihood of death of her infant. The death of a woman, whether or not she is a mother, represents significant deprivation to her family and to society.

Where there are the resources and the commitment, application of current knowledge about maternal and child care and family planning is generally succeeding in reducing mortality rates. However, in some countries, current levels of population growth are undermining many of these gains.

Many mothers do not have access to modern health care services. It is estimated that 60–80% of births in developing countries occur outside modern health care facilities. The majority of these births are attended by untrained persons; some are unattended. The mothers usually give birth in unclean conditions and receive no prenatal or family planning care. The number and distribution of professional midwives are often inadequate: in some areas of the world, the number of midwives in rural areas is tending to decrease, and this trend is unlikely to be reversed in the near future.

Many countries have decided to train traditional birth attendants (TBAs), because these practitioners have already been chosen by mothers, they are intimately involved with women's

reproductive health care, and they have respect and authority in the community. Trained TBAs are expected to conduct clean deliveries and carry out a number of other health care functions. Although some countries have made TBA practice illegal and others have promoted institutional delivery for all, in certain parts of the world TBA training programmes are expanding, as are the functions and responsibilities of the TBAs.

Because of the current shortage of professional midwives and institutional facilities to provide prenatal care and clean, safe deliveries as well as a variety of primary health care functions, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA) promote the training of TBAs in order to bridge the gap until all women and children have access to acceptable, professional, modern health care services. Trained TBAs may contribute to safe motherhood, family planning, child survival, and health for all. Programmes for their training and ongoing support and supervision should be encouraged until more qualified personnel have been trained, are in position in a modern health service, and are accepted by the community.

This Joint Statement on Traditional Birth Attendants constitutes an example of the common purpose and complementarity of programmes supported by WHO, UNICEF, and UNFPA. It reflects their Common Goals for Women, Children and Development in the 1990s, among which are:

- reduction of the maternal mortality rate by half;
- access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late, or too many;
- access by all pregnant women to prenatal care, trained attendants during childbirth, and referral facilities for high-risk pregnancies and obstetric emergencies.[1]

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[1] These Common Goals are among those recently endorsed by over 70 heads of state or government in the Declaration and Plan of Action of the World Summit

1. Introduction

In recent years, with changes in society and modern health care systems, a need to re-examine the definition, role and future of the traditional birth attendant (TBA) has emerged. The purpose of this statement is to clarify the actual and potential role of the TBA in maternal and child health and family planning, identify the issues involved in TBA training and practice, and highlight the advantages and limitations of TBA programmes in order to provide guidance for dynamic health care policies.

This statement is addressed to health care policy makers, doctors, nurses, midwives, managers of maternal and child health and family planning programmes, TBA trainers and supervisors, community leaders, and WHO, UNICEF and UNFPA staff. It is hoped that these people will use this statement as a resource in making decisions at the national and local level. Conditions vary so greatly throughout the world that decisions to initiate, invigorate or discontinue a TBA programme should be made only after a thorough review of the complex array of issues, resources, and sociocultural factors, including the wishes of families and the TBAs themselves.

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for Children. They are also reflected in the International Convention on the Rights of the Child, in the International Convention on the Elimination of all Forms of Discrimination Against Women, and in the Amsterdam Declaration adopted by the International Forum on Population in the Twenty-first Century (1989).

2. Definitions

A **traditional birth attendant** (TBA) is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants.

A **family TBA** is a TBA who has been designated by an extended family to attend births in that family.

A **trained TBA** is a TBA or a family TBA who has received a short course of training through the modern health care sector to upgrade her skills. The period of actual training is normally not more than one month, although this may be spread over a longer time.

Some persons, including family members, may have attended births on occasion but are neither regularly called upon nor expected to assist at birth. These people are not TBAs, although they may become TBAs.

TBAs who undergo extensive training (six months to one year) are then often employed as primary health care workers. They may continue to function as TBAs, delivering babies in their community when asked.

3. Profile and practice of the TBA today

While the individual characteristics of TBAs vary, certain commonalities bridge the continents. A TBA is usually a mature woman who has given birth to live children. She is a member of the community she serves. Though often illiterate, she speaks the language and not only understands but is an integral part of the religious and cultural system. TBAs are generally wise, intelligent women who have been chosen by the women in their family or village for their practical approach and experience. Many TBAs have dynamic personalities and are accepted as figures of authority in the community. TBAs are private practitioners who negotiate their own compensation with clients. Sometimes they receive payment in the form of cash or gifts; usually their compensation includes favoured status in the community.

Many TBAs are designated as the birth attendants for an extended family. In cultures in which this is the norm, TBAs from outside the family, no matter how well trained or renowned, are not accepted. In cultures in which family TBAs are not the norm, the TBA finds clients throughout the village; if her reputation is exceptional, her clientele may reach beyond the village into the surrounding district.

The number of births attended by a TBA each year varies widely. In large extended families, a family TBA may deliver up to 24 babies in a year although 5 or 6 births is more usual. In small families she may attend only 1 or 2 births in a year. The caseload of a TBA who is not designated as a family TBA is usually between 2 and 20 per year, although some renowned TBAs may attend up to 120 births each year. In general, family TBAs have a smaller caseload since their practice is limited by their family; some family TBAs, however, have a larger caseload than TBAs not restricted to serving only a family.

The TBA's traditional role varies widely depending on the local culture and on the roles of other health care providers, including

traditional healers, in the region. The function most universally associated with the TBA is assistance of the mother and family at the time of the birth. This usually includes delivery of the baby, cutting and care of the cord, and disposal of the placenta. It may also involve infant and maternal care, including bathing and massage, domestic chores, and provision of advice during the pregnancy and the postnatal period. In addition, TBAs may perform other functions, depending on local custom as well as on their individual interests and expertise. Many TBAs are consulted for advice on family planning, abortion, and infertility. Some perform circumcisions. Furthermore, there are some TBAs who exercise the broader functions of a traditional healer as herbalists or spiritualists.

Just as the traditional functions of the TBA vary, so do the functions of the TBA who has been trained. She is often expected to augment her traditional functions at the time of delivery by doing what may be termed risk assessment in the prenatal period and referring mothers to the health centre if complications are anticipated or in an emergency. Trained TBAs are expected to upgrade their skills so as to be able to perform deliveries and cord care hygienically and to use appropriate techniques to prevent or control postpartum haemorrhage. Many trained TBAs have also taken on expanded primary health care functions in a variety of fields. These include family planning, first aid, and health education about nutrition, breast-feeding, personal and environmental hygiene, prevention of transmission of the human immunodeficiency virus (HIV), and the importance of bringing infants to the clinic for growth monitoring, immunization, and treatment of infections. Some trained TBAs distribute oral rehydration salts, condoms and oral contraceptives. Most trained TBAs are asked to participate in data collection, at the very least to document mortality of mothers and infants.

4. Goals and objectives of TBA programmes

The *goals* of TBA programmes are to reduce maternal and child mortality and morbidity and to improve reproductive health.

The *objectives* of TBA programmes include the following:

(*a*) enhancement of the links between modern health care services and the community,
(*b*) an increase in the number of births attended by trained birth attendants, and
(*c*) improvement of the skills, understanding and stature of TBAs.

To achieve these objectives the following intermediate objectives may be established:

(*a*) improvement in the understanding of the community of what the modern health care system and trained TBAs can offer to improve the health of mothers and children;
(*b*) involvement of the community in making choices and implementing programmes to improve maternal and child health;
(*c*) training of trainers, health care staff, and TBAs in targeted technical skills and team-building; and
(*d*) institution or improvement of technical support systems for provision of supplies, supervision, and referral.

5. Steps for the implementation of TBA programmes

In order to implement an effective TBA programme with the greatest chance of achieving its objectives, the following steps may be initiated:

1. Involve the community as a whole — including opinion leaders, the women to be served, and the TBAs themselves — in all aspects of the programme from the very beginning.
2. Complete an initial assessment of local needs and resources before developing specific programme plans and policies.
3. Set policies that address all the major issues — including regulation of practice, TBA responsibilities, selection of TBA trainees, trainers and supervisors, recognition of training, remuneration, and reporting procedures.
4. Develop a specific plan to set in place all the necessary elements of the infrastructure — including distribution of supplies, arrangement of transport systems, and upgrading of referral care — before TBA training is undertaken.
5. Decide on methods of evaluation, including process and outcome indicators, and obtain the necessary baseline data.
6. Develop or adapt a curriculum and training materials that are appropriate for adult learners and specific for the TBA functions in the local area.
7. Carry out training of trainers/supervisors, health centre staff and TBAs, placing emphasis upon team-building.
8. Implement community education programmes that complement and reinforce the TBA training.
9. Implement regular, supportive supervision at the TBAs' practice sites, focusing on problem-solving and improvement of practice, and ensure timely and appropriate referral of high-risk and complicated cases.

Follow-up would include the following actions:

10. Initiate continuing education to review skills, look jointly at

the outcomes of referrals, update TBAs on local initiatives and protocols, and increase the health centre staff's awareness of the community's desires and concerns.

11. Carry out periodic evaluation of the programme with the community to assess weaknesses and accomplishments.
12. Adjust TBA programme plans based upon programme evaluation and changing needs.

6. Issues affecting TBA programmes

Certain decisions must be made when a TBA programme is being initiated or rejuvenated. Decisions regarding a particular TBA programme should be made jointly by the interested parties in the community and the health care system. These decisions will vary from country to country and, in some countries, from region to region according to local problems, cultural requirements, available resources, and past experience of the community. The following issues are those that invariably emerge for any TBA programme.

Regulation of practice

After determining whether TBAs are to be recognized and what their legal status is, decisions may be made regarding registration, licensing, and certification. Registration is a listing of TBAs, which may include untrained and trained TBAs. Licensing is an official authorization to practise. Certification is used to designate TBAs who have completed training.

Functions of the TBA

Because of the unique circumstances of each country, there are no globally applicable core functions of the TBA. In each country or region, decisions will be made in accordance with local conditions. The following factors may be taken into account in deciding upon TBA functions: the TBAs' traditional role in the community, the desire of the TBAs and the community for TBAs to take on new roles, the availability of modern health care, and the capacity of the infrastructure to support specific TBA activities. Because of the importance of family planning to maternal and child health, TBAs may be expected to promote family planning and distribute child-

spacing methods that do not require skilled medical supervision. In areas with a functioning health centre, TBAs may also be taught to motivate clients to go to the health centre for injectable contraceptives, intrauterine devices, or sterilization.

Remuneration

Any formal training programme that is initiated through the modern health care system will open up the issue of remuneration among the trainees. Decisions to pay TBAs a wage may be based on how such an innovation will influence the interactions of the TBAs with their clientele as well as financial ability to sustain such a system.

Selection of TBAs for training

No matter what criteria are used to select TBAs for training, decisions about selection should be made by or with the community. Criteria for selection may include motivation, caseload, respect in the community, age, literacy, or any other factors that are deemed appropriate given the local circumstances and desires.

Selection of trainers and supervisors

Decisions about selection of the trainers and supervisors of TBAs will ultimately be based upon local resources and realities. Criteria for trainers may include age, midwifery experience, fluency in the local language, experience in teaching nonliterate people, motivation, and possibility of acting as TBA supervisors following training.

Content of training

The training of TBAs is most effective when it is directed at upgrading skills for simple, focused tasks to combat a particular

problem. Research has not yet shown TBAs to be effective when they have taken over a broad array of primary health care functions.

Recognition of training

Training may be recognized in local ceremonies, which may include the presentation of certificates and TBA kits, supplied by UNICEF or UNFPA, or made locally. A wide range of possibilities for recognition, based on local customs and choices as well as available resources, may be explored in addition or as an alternative to monetary remuneration.

HIV transmission

While TBAs have always been at risk of contracting as well as transmitting communicable diseases, the current problem of HIV, the causative virus of acquired immunodeficiency syndrome (AIDS), and the threat of its increasing spread in the 1990s deserves special attention. TBAs who do not know it already will come to realize through training that their work puts them at risk of acquiring HIV. Decisions will need to be made not only about whether TBAs will be asked to become involved in AIDS education but also about how they will protect themselves. The supply of gloves for use by TBAs may be considered. TBAs may also be involved in distributing condoms in the community.

Technical support systems

TBA programmes involve a great deal more than merely TBA training. While demonstration and pilot projects, or small-scale programmes developed by nongovernmental organizations, are often successful, their impact and effectiveness frequently fall short of the results expected when they are expanded to the national scale, unless the technical support required is rigorously maintained. Thus, effective programmes are best developed in

the broader context of overall maternal and child health and family planning programmes, rather than as a separate activity. The effectiveness of the TBA is dependent on the supplies made available to her and to the referral centre, on the supervision of the TBA, and on the existence of a realistic and effective referral system. Decisions made about the type of technical support needed will vary with circumstances. However, investment in TBA training should only be made if an adequate system of support and supervision to sustain the programme can be ensured.

7. Limitations of TBA programmes

There are a number of limitations in TBA programmes. These include the following:

1. Illiteracy greatly restricts the effectiveness of TBAs by limiting their ability to carry out many functions, including record-keeping, written communication with health care staff about clients for referral, and prescription of drugs.
2. If most of the TBAs in a country or region have a small caseload, training may not be cost-effective because the trained TBAs will not be able to keep up their skills through regular practice.
3. TBA programmes are costly even when individual caseloads are large. When the expense of surveys, planning, development and production of training materials, upgrading of referral systems, and support of regular supervision is added to the costs of the training sessions, a good TBA programme may account for a substantial proportion of the health care budget.
4. Working outside the institutional environment, even the best-trained TBAs are limited in the measures they can employ to save a life because they cannot perform many essential obstetric functions; these can only be carried out in a health centre or hospital. Where transport is inadequate, a TBA cannot save the life of a mother who needs blood, intravenous medication, or surgery.
5. The trained TBA is not a substitute for the professional midwife. While the experienced TBA may become confident and adept at performing certain manual procedures, the limited depth of her training makes her less able than the professional midwife to make critical judgements, to treat the wide range of complications associated with pregnancy and birth, and to prevent complications in the mother and newborn infant through individualized health teaching.

6. Training of TBAs cannot be used as a single approach to improving maternal and child health care. Without implementation of appropriate technologies and strengthening of referral and support systems, TBA training alone cannot contribute to a substantial improvement in health care. Furthermore, trained TBAs cannot be expected to reduce overall mortality and morbidity rates when poverty, illiteracy, and discrimination — the underlying causes of these problems — are not addressed.

8. The future

For so long as women give birth without the assistance of a trained birth attendant, TBA training will provide the potential to decrease maternal and child mortality and morbidity, by dispelling ignorance, decreasing harmful ritual practices, and promoting safe practices and use of the modern health care system. How long this interim measure of training TBAs will be of benefit will depend on the perceptions and health-care-seeking behaviour of the community as well as the capacity of the modern health care system to offer professional care. This will vary from country to country.

Some programmes have as their goal the integration of the TBA into the health care team. Full integration is probably impossible since the TBAs would become trained, paid health workers whose functions would assume more of a technical character, removed from their cultural context. They would become primary health care workers absorbed into the modern health care system and would no longer be TBAs. The focus of TBA programmes should not be to mould TBA practice to that of the medical model. Rather, TBA training should help TBAs to perform more safely the tasks that they already perform. The role and identity of TBAs need to be maintained so long as they are needed and continue to be recognized by the community in health and cultural matters. In this way, TBAs are linked with, rather than integrated into, the modern health care system.

Where TBAs are currently practising, it is not necessary either to transform them into a new category of health worker or to reject them. TBA training should not be viewed as a permanent solution to meeting the health care needs of mothers and children, neither should TBAs be considered a substitute for the "disappearing midwife" — a phenomenon that is becoming apparent in a number of countries. Where there are the resources and the desire, simple, focused training based on limited and realistic TBA functions will help in the transition to providing professional care for all. Over a period of time, it is

envisaged that the utilization of TBAs will diminish as the goal of safe motherhood is approached.

There will be a time when much of the information and skills now being taught in TBA training programmes will be taught to all women. This knowledge will be of use whether they are attending births, planning for the births of their own children, or evaluating the care they receive from their birth attendant, whether TBA, professional midwife or obstetrician.

As literacy programmes achieve success, there will be a new group of women to attend births. These literate women, some of them daughters of illiterate TBAs, along with the community and the health planners, will then need to decide whether they will be trained as TBAs, auxiliary midwives or professional midwives. The decision will be made country by country, and it is anticipated that there will be no single approach to the transition to the ultimate goal of professional maternal and child health and family planning care for all.

In any event, there will always be a need to keep what is best in TBA care: the sense of caring, the human approach, and the response to cultural and spiritual needs. For a long time to come, even when women have access to modern health care and the services of a professional midwife or physician, they will also seek the care of the traditional healers and birth attendants for advice and complementary care until the modern health care system can meet all the needs of its clients.

9. Role of WHO, UNICEF, and UNFPA

In countries where TBAs attend a significant number of deliveries and where such action is consistent with the individual country's health care policies, WHO, UNICEF, and UNFPA will undertake a coordinated effort, each within its own mandate, at the country level to:

1. Promote a flexible approach, adapted to local conditions, for upgrading maternal and child health and family planning care through the utilization of TBAs.
2. Support the training of TBAs where they are likely to have a significant effect on the health of women and children.
3. Collaborate in the development of complementary TBA training programmes with training strategies suited to the country situation.
4. Serve as a model or resource to nongovernmental organizations in TBA programme planning.
5. Provide logistic support to strengthen supply, supervision and referral systems.
6. Provide TBA kits or simple disposable delivery kits to ensure clean deliveries.
7. Support research to study the role and impact of TBA programmes.