Evaluation
FINDINGS
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SUPPORT TO TRADITIONAL BIRTH ATTENDANTS

UNFPA has supported Traditional Birth Attendants (TBAs) programmes since 1970 to improve maternal evaluation and child health and as part of the Safe Motherhood Initiative since it started in 1987. In the 1990s, UNFPA jointly with WHO and UNICEF**,** issued a statement on TBAs to reflect common goals to contribute to the global effort aimed at improving reproductive health. The objectives of the support to TBAs in this statement are to: a) enhance the links between modern health care services and the community; b) increase the number of births attended by trained birth attendants and, c) improve skills, understanding and stature of TBAs. The International Conference on Population and Development held in 1994 in Cairo further encouraged the agenda of the Safe Motherhood Initiative including the objective that all births should be assisted by trained persons.

A thematic evaluation was conducted in 1994-1995 to assess the effectiveness of UNFPA support to TBAs as a strategy to improve maternal and child health and family planning services. This evaluation was based on a sample of UNFPA supported projects in seven countries: Bolivia, Ghana, Iran, Malawi, Nepal, Syria and Uganda, which represent a wide range of country situations and experiences with programmes of support to TBAs. In all selected projects, training of TBAs was one of the strategies selected to achieve the objective of improving the quality and coverage of MCH/FP services.

The evaluation collected information from TBAs, women in communities served by TBAs, service providers at the first level of referral and trainers in TBA programmes. Information was also obtained from the staff of Ministries of Health at policy and programme management levels.

The TBAs interviewed were generally older women (in two case studies some TBAs were men) who were respected by their communities. The majority was illiterate and had learned their skills through working with other TBAs. Most TBAs considered themselves as private practitioners who responded to requests for service and received some compensation, mostly in kind. The focus of their work was to assist women during delivery and immediately post-partum. Frequently their assistance also included helping with household chores. Most TBAs went to the woman's house to deliver although some had arranged a delivery area in their own house or compound. The majority of the TBAs interviewed resided in poor rural areas, very distant from health facilities. They often served as a bridge with the formal health system, sometimes accompanying women to health facilities. The Iran case was different from all others in that it was a programme aimed at training a cadre of service providers to replace TBAs. The trainees in the programmes were young (age 18-30) and had some years (4-5) of schooling.

I. MAJOR FINDINGS

All programmes reviewed reported an improvement in the quality and coverage of maternal and child health services as a result of training TBAs. The lack of baseline data and a systematic method to collect information during the implementation of the programme, however, hindered the quantification of the impact.

The training programmes reviewed reported that TBAs can learn new skills to provide safe and clean care to the mother and the newborn. Communities, TBAs and health providers at the first level of referral all drew attention to the changes in TBA practices after training. Trained TBAs practise clean delivery, advise mothers on basic pre-natal care, identify risk signs and make referrals. Also, trained TBAs have contributed to increasing the number of women going to health centres for family planning and immunization services.

Cases reviewed showed that TBAs can make the most impact in preventing maternal and neonatal infections. They can prevent post-partum sepsis by applying the "three cleans" during delivery and following placenta management procedures. They also can contribute to decreasing maternal and neonatal deaths due to tetanus by referring women for tetanus toxoid immunization and by conducting an aseptic delivery. In locations where referral is feasible, TBAs can save lives through identifying risks and conducting required preventive measures before arrival at the referral site.

Therefore, through funding training programmes, UNFPA has contributed to achieving the defined objectives for supporting TBAs regarding MCH/FP care. For this reason, TBA Programmes should be supported particularly in those countries where a large proportion of deliveries is attended by TBAs and quality maternity care is not accessible to the majority of the population. At the same time, experience has also shown that the achievements of past interventions were seriously limited mainly by their narrow scope as well as vertical and thus, isolated approach (see Box I).

The findings of the evaluation also highlighted important limitation to the effectiveness of the programmes:

- *Lack of integration of TBA Programmes with general strategy for maternal and child care*

TBA programmes supported by UNFPA were often vertical and focused almost exclusively on training activities. Inadequate attention was paid to developing follow-up systems to support, supervise and evaluate trained TBAs. Training activities were conducted in an uncoordinated manner, outside of the broader strategy to improve maternal and childcare. Bolivia, Nepal and Iran reported that programmes were developed as vertical efforts with separate staff and resources and that they continued to be so after many years of implementation.

An important factor contributing to the vertical approach is that external donors remain the exclusive source of funding of TBA programmes in most cases. National budgets for such programmes have not increased in the past decade due partly to the lack of conviction among policy makers of the value of TBA Programmes. Even though most policy makers interviewed expressed support of TBAs, some favoured instead an emphasis on improving women's access

to the formal health system. The strength of support was usually related to the extent of their exposure to TBAs. By the same token, the attitudes of the health staff at the first level of referral toward TBAs were more positive as compared to the health staff at the district and provincial levels. It appears that at the local level, where they are closer to the health centre, TBAs are valued more for their work, resulting in more effective collaboration.

BOX I

The TBA programme in the Upper East Region in Ghana, supported by UNFPA, tracked antenatal visits and deliveries conducted by trained TBAs during 1990 to 1993. Antenatal visits increased from 20,000 to 180,000. Deliveries reported by TBAs increased from less than 10,000 to 50,000. Nationally, the percentage of TBA deliveries as a percentage of supervised deliveries, increased from 16.4 percent to 22.2 percent between 1992 and 1993.

Policy makers and programme managers state that TBAs have contributed to:

- Improve pre-natal care,
- Increase contraceptive acceptance rate, and
- Decrease neonatal tetanous admissions.

TBA Programmes, where undertaken, should be part of the broader national strategy to improve Reproductive Health Services and include an effective referral system. It is essential to ensure that emergency obstetric services are available at the site where TBAs refer. A mechanism for monitoring, supervision and evaluation of TBA performance should also be an integral component of such programmes.

- *Changing TBA's role*

Policy makers and programme managers favoured adding primary health care tasks to TBAs. Some of these new tasks are: giving advice on health matters, promotion and distribution of family planning methods, distribution of oral rehydration solution and iron tablets, referral for pre and post-natal care and for vaccinations. The addition of new tasks has changed the focus of the TBA's role from its traditional one to that of a multi-purpose community health worker leading to the perception that they have become part of the government health network. This has resulted in some cases in reluctance to pay TBAs for their services.

It was observed that communities generally lacked understanding of the linkage between the formal health system and the trained TBA, although some TBA programmes, such as Iran and Ghana, included a component to promote understanding of the purpose of the training to gain support for the TBA's work. In such programmes, managers or trainers met with community groups to discuss the purpose of the TBA training, the TBA's linkage with the health

centre and the need for community support. It was found however, that when such orientation was conducted, it had not been sufficient. Interestingly, some communities, on their own initiative, were organized to provide food for the TBA's family while in training, and had arranged for a transportation system in case of obstetric complications.

Most programmes reviewed had not assessed beforehand the pertinence of the tasks to be added, nor their acceptability to TBAs. Evaluation findings show that TBAs are more receptive to skills improvement directly related to their traditional role in delivery and immediate post-partum care, for example regarding improved hygiene during delivery and post-partum infant and mother care.

If TBAs are given additional tasks, these should be based on an assessment of the TBA's role in their community to ensure that both TBAs and communities perceive them as appropriate.

- *Quality of TBA training is deficient*

Most programmes did not undertake any needs assessment to derive an information base for developing an appropriate curriculum for TBAs. Curricula development was based only on what programme managers thought TBAs should know. A number of case studies reported curricula which were complex and too comprehensive for TBAs. In Nepal, the curriculum was judged to be very advanced for TBAs and the time planned for the training. In Iran, trainers reported difficulties among the trainees with retaining all the imparted content. And, as trainers were generally not well prepared in training methods, the learning process for trainees tended to be a very arduous one.

Training of trainers was often short and not well structured to prepare them adequately. Often, expertise in the clinical content was considered sufficient without taking into consideration pedagogic skills. Most programmes lacked education materials (models) for demonstration in training.

The family planning component of TBA training programmes was found to be weak. In most programmes it was focused on a description of contraceptive methods only. Neither the health benefits of family planning nor the communities' perceptions and concerns with respect to family planning were adequately addressed. In some cases, i.e. Ghana, Uganda, the weak training was redressed to some extent by supervision of TBAs in their role of family planning promotion and distribution. As a result, TBAs in these countries reported greater confidence and were more active in these activities. TBAs who were not supervised, e.g. Syria, Bolivia, felt more uncomfortable discussing family planning. Most case studies stated that TBA's role in family planning was to promote and refer. Some programmes included contraceptive distribution limited, however, to condoms and spermicidal foam tablets.

An assessment of the communities' health beliefs and practices should serve as the information base for the selection of appropriate topics and teaching methodologies of TBA programmes. Training of trainers in pedagogic techniques for illiterate adult learners should also be considered a critical element for the effectiveness of programmes.

BOX II

TBAs in Nepal said that they promote family planning and distributed condoms only although they said that community members were "too shy to get condoms from them." To overcome shyness, in Ghana some TBAs used "agents" (community health workers, usually young males) to distribute condoms. Other TBAs said that they preferred just to refer clients to health centres for family planning.

TBAs who oriented women on family planning methods discussed mostly the condom, pill and IUD methods. TBAs also pointed out that when women had complications it was difficult to encourage them to continue a method.

In Malawi and Uganda, TBAs who were herbalists also prescribed traditional family planning methods and "treat infertility".

Evaluation of TBA's performance immediately after the training was done by some programmes, often through observing the repetition of skills taught by simulation. Most training programmes, however, did not include follow up evaluation to assess behaviour change in trained TBAs. Some programmes assessed change through monitoring differences in the number of referrals after the training. In most receiving institutions, however, records/assessments of TBA referrals were not kept. In Malawi, the number of complicated deliveries reaching hospitals were reported to increase as a result of TBA training. However, health centres visited had no assessment record of the condition of the patient upon arrival, thus, it was not possible to conclude whether the trained TBAs had made proper and timely referrals.

To assess TBA's contribution to women's reproductive health more accurately, projects supporting TBAs must include in their design a method to collect information systematically for monitoring and evaluation purposes. Specific qualitative and quantitative indicators should be identified.

- *Trained TBAs are seldom supervised*

Even though policy makers and managers stated emphatically that supervision is one of the most important factors for a successful TBA programme, findings showed that supervision was acutely limited in almost every country. The more rural the TBA, the least frequent she reported to have been visited. Supervision was restricted by lack of funds, lack of transport and limited staff.

TBAs who were supervised regularly, reported a more positive attitude toward the health system, felt supported in their work and tended to refer more clients. Although, when supervision did take place, findings show that it was focused mainly on checking supplies,

records and discussing general issues. There was very limited supervision of TBAs in specific techniques taught, discussion of delivery cases and issues related to handling emergencies.

Supervision of TBAs in case studies did not usually allow supervisors to observe TBAs conducting deliveries. In some cases, i.e. Uganda and Iran, however, TBAs who accompanied a woman for delivery sometimes assisted the delivery at the health centre together with the health provider. In such cases, health providers had the opportunity to observe the TBA and provide feedback.

TBA training programmes should always include arrangements for post training supervision with adequate logistical support.

- *Locally developed TBA Kits are more functional and sustainable*

Most programmes had difficulty maintaining adequate supplies for TBAs to conduct clean deliveries. Replenishment of supplies was often planned in conjunction with supervision visits which were irregular. Some TBAs depended on the programme to restock supplies, others tried to replenish them themselves. Some clients replaced or paid for supplies used.

In a number of programmes, donors were the principal source of supplies contained in kits, which were generally large and durable. The use of the kit varied. For some TBAs it was a sign of prestige which showed that she had been trained. Other TBAs stated that kits were large, heavy and difficult to carry. Therefore in some countries, i.e. Nepal, Bolivia, simple, locally made home delivery kits had been developed with the aim to make them more appropriate, functional and inexpensive. The experience with producing and selling inexpensive clean home delivery kits to TBAs and/or families was beginning to be studied.

Locally produced kits seem to be more cost effective for ensuring availability of supplies for TBAs to conduct clean deliveries.

- *Criteria for referral differ significantly among managers and trained TBAs*

The criteria for referral imparted in training programmes varied from those actually used by TBAs. Many managers used broad classifications to define risk and encourage TBAs to refer for most risk categories. The programmes in Uganda, Malawi and Ghana used the classifications of “too young, too old, too many pregnancies” as reasons to refer women to health facilities. Bolivia’s programme managers stated that most problems should be handled by health staff. TBAs, however, stated that they did not adhere to these criteria for referral. In addition, they also took into consideration cost, time and distance of travel, availability of transportation, care of remaining children, days lost at work and views of husband and mother-in-law in referral decision-making. The lack of adherence to criteria taught in training appeared especially true if the TBA lived in remote rural areas and had previous experience dealing with some risk factors.

As a result, in most case studies TBAs conducted deliveries considered by programme managers as high risk. Some managers interpreted this as a demonstration that TBAs were not aware of their own limitations. Others stated that it was an indication of the need to define a more realistic referral system, which takes into account logistics and the capacity of the health system to respond to obstetric complications.

There is an urgent need to develop effective referral systems, which take into account logistics for referral and the capacity of the referral site to respond to obstetric complications.

- *In case of complications, programmes differ on TBA's actions*

Training with respect to cases of hemorrhage, obstructed labor, sepsis and related conditions differed across programmes. Some programmes focused on training TBAs only to refer in such cases. Managers of these programmes, even though they acknowledged logistics and service capacity difficulties, maintained that the Ministry of Health should concentrate on increasing coverage of the health system and not on training TBAs to handle complications. Other programmes have begun to train TBAs in certain techniques to control hemorrhage, such as fungal pressure, nipple stimulation and rehydration. For obstructed labor, TBAs are taught to identify the proper time to organize transportation to a hospital.

Studies to assess specific TBA interventions in case of obstetric complications should be conducted and the findings incorporated into training programmes.

- *Most women expressed their preference for TBA's assistance during delivery.*

In programmes reviewed, women repeatedly reported reluctance to seek care from health centres. Health staff were described as impersonal, rude and arrogant. TBAs, knowing that women were poorly treated, sometimes also chose not to refer. If they did, TBAs said that they would lose credibility and women would seek assistance of untrained TBAs who, most likely, would not refer them.

BOX III

Discussing preferences for care, women interviewed in Bolivia stated that they preferred TBAs as they are afraid of doctors. "Doctors treat us bad, leave us alone, undress us in front of others and sometimes they shave and "cut" us (given an episiotomy")

In Syria, women interviewed also stated their preference for TBAs. They commented TBAs provided them more human treatment, respected them more and were easily accessible.

Policy makers and managers stated, on one side, that maternal mortality will not decline if women do not seek services at health facilities. On the other side, women insisted that they did not want to seek care where they were badly treated. Thus, trained TBAs, caught in the middle, acknowledged their difficult position because they believed they could not encourage clients to seek care which was perceived as of poor quality.

Reproductive health programmes need to ensure that the service provided at the referral site is appropriate to the community served. In this effort, TBAs should be considered a key person to provide information on the communities' perceptions and needs regarding health matters.

II. CONCLUSION

There are still many countries where a large proportion of the population does not have access to health services, relying on TBAs (and traditional healers) to meet their health care needs. In these countries, TBAs who have been trained can contribute to improving maternal and child health, as they offer the only means by which women in rural communities have access to a clean delivery.

Evaluation findings identified critical aspects where TBA programmes need to be improved. To increase their effectiveness, programmes should be part of the broader national strategy to improve reproductive health. They should not focus solely on a training component and should include adequate supervision, transportation and provision of supplies. In particular, TBA programmes should increase efforts to ensure the availability of supplies to conduct a clean delivery since this is essential for TBA's to follow aseptic procedures. In this regard, locally produced TBA kits seem more practical and sustainable.

The quality of TBA training can be improved through an assessment of the communities' health beliefs and practices beforehand to:

- ensure appropriateness of the training content
- ensure TBA and community acceptance if new tasks are to be added
- select pertinent training methodologies
- define a relevant and applicable evaluation methodology

Training of trainers in pedagogic techniques for illiterate adult learners should also be considered a critical element of the programme.

The family planning component of TBA training also needs to be improved by acquiring a better understanding of the communities' beliefs and concerns. Findings of socio-cultural research should serve as an important information base for designing the training content. The family planning component should also be part of reproductive/family health promotion and not focused only on contraceptive methods.

Although the importance of the TBA's role in referral is universally acknowledged, most programmes have not developed an effective referral system. Programme managers need to review the current classification of risk to take into account the criteria for referral used by TBAs, which includes conditions for referral (time, cost, transportation, etc). Criteria for referral should also reflect the capability of health services and hospitals to provide services for obstetric complications and emergencies.

Finally, where TBA programmes are undertaken as part of the strategy to improve reproductive health, special attention should be given to the quality of care provided at the

referral site. Policy makers need to assess the attitudes and behaviour of health staff toward clients and identify strategies to improve the appropriateness of the services provided. In an effort to improve quality of care, TBAs should be considered a key partner since they can provide information on the communities' health perceptions and needs.

This issue of *Evaluation FINDINGS* is based on findings, conclusions and recommendations drawn from an evaluation report entitled "Traditional Birth Attendants" published by the Office of Oversight and Evaluation.

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