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Citation for author's submitted version

Citation for publisher's version

Notice: The publisher's version of this work can be found at:
http://dx.doi.org/10.1016/j.jmwh.2004.01.005
THE EFFECT OF SHIFTING POLICIES ON TRADITIONAL BIRTH ATTENDANT TRAINING

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Précis
In an effort to decrease maternal mortality, policy makers have struggled to identify the contributions of professional and traditional birth attendants.
ABSTRACT:
Traditional Birth Attendant (TBA) training commenced in many places in the non-Western world in the 1970s, supported by the World Health Organization and other funding bodies. By 1997, senior policy makers decided to refocus priorities on the provision of ‘skilled attendants’ to assist birthing women. The definition of ‘skilled attendants’ excluded Traditional Birth Attendants and resulted in the subsequent withdrawal of funding for TBA training globally. A review of the health and sociological literature and international policy documents that address TBA training revealed how international policy and professional orientation is reflected in education programs designed for the TBA. Policy makers risk ignoring the important cultural and social roles TBAs fulfill in their local communities and fail to recognize the barriers to the provision of skilled care. The provision of ‘skilled attendants’ for all birthing women cannot occur in isolation from Traditional Birth Attendants who in themselves are also highly skilled. This paper argues a legitimacy of alternative worldviews and acknowledges the contribution TBAs make to childbearing women across the world.

Keywords: Traditional Birth Attendants, Skilled Attendants, maternal mortality, midwives

Biographical Sketch:
Sue Kruske, CNM, B Hlth (Hons), is a nurse-midwife, currently undertaking her PhD at the University of Technology, Sydney. Her area of interest is improving health services for marginalised groups through improving the health professionals’ acknowledgement and respect of different world views.

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INTRODUCTION
Sixty percent of all births in the world occur outside a health facility with 47% of all births assisted by a Traditional Birth Assistant (TBA), family member or no one at all. In rural areas of some non-Western countries, up to 95% of women giving birth are attended by TBAs. Western policy makers have influenced the recognition and training of TBA since the early 1970s. This paper presents the results of a literature review of the health literature and a critique of the policy documents that was carried out in an attempt to understand and explain the relationship of policy to the role and position of TBAs today.

METHODS
A search strategy was conducted of electronic databases from 1970-2003. Information was sourced from CINAHL, Medline, PubMed, Sociofile, Academic Search Elite, Cochrane Database of Systematic Reviews, PsycINFO and Factiva. Key words included: traditional birth attendant, maternal mortality, TBA training, skilled attendants and safe motherhood. The literature reviewed included health reports, policy documents and international research articles. In addition, policy documents and reports from 1970 were sourced from World Health Organization (WHO), The World Bank, Safe Motherhood, United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), Family Care International and the Regional Prevention of Maternal Mortality. Over 200 documents were reviewed for reference to TBAs and their training.

BACKGROUND
The World Health Organization definition of the TBA is ‘a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs’. A TBA is usually female, over 40 years of age, a mother and a member of the community, chosen by that community to assist women in childbirth. She learns her skills through apprenticeship that involves both observation and imitation in contrast to the didactic style of education of professional midwives typical of Western systems. A TBA is often highly regarded by the community. She is not usually reimbursed financially though often receives goods or services, for example, food, cloth or assistance with domestic tasks from her clients.

Whilst TBAs make up a significant proportion of the world’s accoucheurs, recognition of their status varies between countries. TBAs practice illegally in some countries such as Syria, Turkey and Lebanon. Other countries including Tanzania, Zambia and Sri Lanka, do
not officially recognize TBAs but allow them to practice. In other countries such as Pakistan, the TBA is not only recognized but employed to work within the health care sector as well as providing care to childbearing women at home. While the status of birth attendants in many communities is high, other societies consider birth unclean and hence the status of the TBA is low, as their role is to deal with the ‘pollution’ attached to birth, keeping it clean for others. Some TBAs may only provide social support for the occasional birth while others provide full antenatal, intrapartum and postnatal care for as many as 50 to 60 women per year.

THE HISTORY OF TRADITIONAL BIRTH ATTENDANT TRAINING
Since the early 1920s, isolated episodes of TBA training were undertaken by colonial powers and missionaries in the non-western world as part of their efforts to provide health care and education. But it wasn’t until the 1970s that leading policy makers identified the potential of the TBA to lower the high maternal and infant mortality and morbidity rates. In 1978 an international conference on primary health care held in Alma Ata released a declaration calling for urgent and effective action to develop and implement primary health care throughout the world and particularly in developing countries. This document noted that TBAs were, in most societies, an important part of the local community and therefore it was ‘well worthwhile exploring the possibilities of engaging them in primary health care and training them accordingly’. The WHO actively promoted the training and recognition of TBAs throughout the 70’s and 80’s. In 1972, twenty-four countries had some form of TBA training and by 1982, fifty-two countries were providing training programs for TBAs. In 1982, WHO was confident that with stronger and expanded programmes, trained health workers (which included TBAs) would attend two-thirds of births by 1989. Encouraged by the numbers of TBAs receiving training throughout the ‘80s, WHO encouraged health planners in 1990 to promote the provision of trained birth attendants for all women. Unfortunately there was, at least in some countries, little quality control in the design or content of these programs.

In 1987, a group of international agencies, (WHO, UNFPA, UNICEF, The World Bank, the International Planned Parenthood Federation, and the Population Council), sponsored the first international conference on safe motherhood in Nairobi, Kenya. The aim of the conference was to draw attention to the dimensions and consequences of poor maternal health in developing countries, and to mobilise action to address high rates of maternal death and illness. These sponsors became the founding members of the Safe Motherhood Inter-Agency Group (IAG) and the Safe Motherhood Initiative was launched with the goal of
reducing maternal mortality by 50% by the year 2000. Members of the IAG have significantly influenced global policy development and funding support for birthing services and TBA training. The IAG was further strengthened when the International Confederation of Midwives (ICM), the International Federation of Gynecology and Obstetrics (FIGO) and the Regional Prevention of Maternal Mortality Network (Africa) joined the coalition in 1999.

Initially, training programs focused on lowering the maternal mortality rate (MMR) by encouraging TBAs to conduct antenatal care and improve intrapartum and postpartum practices. Not surprisingly, this was taught according to current Western medical ideology and practice. The WHO and other leading health bodies anticipated that the provision of antenatal care would lead to the detection and early referral of complications. With training, TBAs were expected to reduce infection and postpartum hemorrhage rates which remain two of the five major causes of death in women in pregnancy and childbirth. Infection rates could be decreased by the improvement of hygienic practices such as hand washing, use of gloves and cord care while hemorrhage rates could be lowered by the correct management of third stage of labour. Antenatal and intrapartum education promoted the prompt referral of complications by the TBA to other professionals but was not able to address access, costs or acceptability of referral by women or their families.

Training courses varied in content and length of between several days to several months with the majority occurring over two to four weeks. Evaluations measured many outcomes including the knowledge, attitudes and behavior of the TBA. For senior policy makers however success was focused on one indicator – the ultimate reduction in mortality rates.

**EFFECTIVENESS OF TBA TRAINING**

Despite the growth of TBA training programs, maternal mortality did not decrease. New figures, in fact, revealed 585,000 maternal deaths globally in 1990 – 80,000 more deaths than previous estimates. Because techniques used to measure mortality have been refined and modified, it is therefore not possible to make comparisons with previous figures.

World policy makers assumed that practical difficulties such as poor literacy and lack of ‘scientific knowledge’ was preventing trained TBA’s from effectively lowering the MMR in countries that had invested in TBA training. This assumption appears to have led to the 1992 Joint WHO/UNFPA/MCH statement that declared TBA training and use be considered only an interim measure until ‘all women and children have access to acceptable, professional, modern health services’. There appeared little understanding in policy
statements at that time of the importance of social factors such as poverty, gender status, or lack of transportation (less modifiable variables) influenced choices and behaviors in the presence of birth complications. Also at that time there remained a preoccupation with the (subsequently proven unfounded) capacity of antenatal care and the use of risk assessment in preventing death.\textsuperscript{11, 24}

In 1996, aware that maternal mortality rates were increasing or at least remaining consistent, policy leaders in WHO altered the language in policies addressing safe motherhood from ‘trained attendant’ to ‘skilled attendant’ after recognizing that someone who has received training is not necessarily skilled.\textsuperscript{19} WHO concluded that the term trained ‘\textit{implies but does not guarantee the acquisition of knowledge and ability, whilst ‘skilled’ implies the competent use of knowledge}’.\textsuperscript{19}

In 1997, the Safe Motherhood Technical Consultation was held by the IAG in Sri Lanka to review the key lessons learned after ten-years of the Safe Motherhood Initiative. This meeting resulted in the endorsement of ten key ‘action messages’ that had been developed by the IAG.\textsuperscript{19} (Table 1) The first three action messages were directed toward changing the political environment around women’s health and empowerment issues. The remaining seven were related to the design and implementation of programs, including the delaying of first birth, prevention of unwanted pregnancies and the provision of quality maternity services.\textsuperscript{19}

\textbf{INSERT TABLE 1 HERE}

The presence of a health worker with midwifery skills at birth with appropriate back up was argued to be the most critical intervention for making motherhood safer.\textsuperscript{19} Key Action Message Number Six stated ‘ensure skilled attendance at delivery’.\textsuperscript{19} This would have a profound affect on the recognition and support of TBAs as the IAG definition states: ‘\textit{A skilled attendant refers exclusively to people with midwifery skills (for example doctors, midwives, nurses) trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications}’.\textsuperscript{25} TBAs fall outside this definition because ‘they lack the capacity to manage obstetric complications’.\textsuperscript{26}

It appears, by focusing on the attendant’s capacity to respond to obstetric emergencies, policy makers ignored other skills and expertise of the TBA. The decision to withdraw support for TBA training, and reallocate it to the promotion of ‘skilled attendants’ training was made on the ‘evidence’ that world wide maternal mortality rates were not falling.

However using mortality rates as the most important and sole indicator of successful TBA training is highly problematic due to the absence of reliable mechanisms to measure
maternal mortality. Underreporting and misclassification is endemic in all methods used across the world and therefore current and previous statistics are unable to be used to evaluate trends. In addition to these problems, there is new evidence emerging that contradict the negative assessment of TBA training that influenced policy makers at the 1997 Safe Motherhood Technical Consultation. A recent meta analysis of TBA training by Sibley and colleagues found that TBA training was associated with substantial and significant improvements in TBA 'knowledge' (90%), ‘attitude’ (74%), ‘behaviour’ (63%) and ‘advice’ (90%). TBA training was also associated with small but significant decreases in peri-neonatal mortality (6%) and birth asphyxia mortality (11%). The meta analysis was unable to adequately assess the impact on maternal mortality due to incomplete reporting.

WHY TBA TRAINING APPEARED INEFFECTIVE IN LOWERING MATERNAL MORTALITY

There are many reasons given for the apparent lack of success in TBA training to reduce maternal mortality. Poverty, low levels of literacy and the poor social and economic position of women, are now better understood as contributing factors that prevent significant improvements in health outcomes for women. The high rates of illiteracy in the TBA population inhibit the effectiveness of western style education systems that rely on a literate audience. Other reasons influencing the success of TBA training include inadequate supervision and lack of access to referral services. When referral centers are accessible, other factors such as cost, time and travel distance, availability of transport, care of remaining children, days lost at work and influence of the woman’s husband or mother-in-law may affect the decision to refer women. Other reports suggest that when women do access referral centers, the quality and provision of obstetric care can be problematic.

The quality and delivery of the education programs have also been criticized. Training curriculums were developed using biomedical ‘evidence’ and ignored the differences of worldview of the recipients. These courses were often simplified versions of the professional midwives’ own training or direct translation of WHO guidelines irrespective of the appropriateness to the local situation. Indeed western beliefs were at times imposed without any consideration of how the new information related and interacted with birth systems already in place in different cultures. In some cases, the trainers, many of them professional midwives, dismissed the importance of local customs and practices, seeing them as barriers to improved maternal health.
There was also limited consideration of the value of placing the information being taught within the local context. For example, active management of third stage has been proven to be efficacious in reducing rates of postpartum hemorrhage. Active management involves the administration of an uterotonic (for example oxytocin or misoprostol), controlled cord traction with guarding the uterus and uterine massage after delivery of the placenta. Without access to uterotonics, controlled cord traction prior to placental separation could increase complications rather than prevent them. Likewise the capacity to manage a retained placenta without adequate knowledge of physiology could have equally negative outcomes.

Consultations with the recipients of the training and the community they served were rare and therefore modification or tailoring of programs limited. Rarely was local knowledge incorporated into education curricula nor were professionals encouraged to work in equal partnership with TBAs.

The devaluing of traditional aspects in birthing is reflected in both international policies and the clinical practice of many professional midwives and doctors who consider western-based knowledge and education as the only legitimate form of knowledge. Western biomedical knowledge is largely adopted by non-western countries and often results in the continuation of western obstetric practices long after they were abandoned in many countries in the western world. For example, there is now strong evidence that the routine use of enemas, episiotomy, immobility in first stage of labor and delivery in the dorsal or lithotomy position do not improve childbirth outcomes and may contribute to poorer outcomes.

The attitudes of health staff at hospitals also influenced the likelihood of TBA referrals. Initial attempts to train TBAs were often met with resistance from doctors and midwives who had a vested interest in maintaining the status quo. They regarded traditional medicine and practices as harmful and based on ignorance and superstition. The knowledge of TBAs, including those trained by health professionals, was seen as inferior and lacking professional status. In many countries nurse-midwives will only work as superiors to TBAs. This is reinforced by policy documents from WHO, World Bank and other IAG members that use language such as ‘trained’ versus ‘skilled’ and ‘professional’ versus ‘traditional’.

The exclusion and devaluing of the TBA is not restricted to expatriate western professional midwives working in non-western environments. Professional midwives trained in the non-western world, within a Western medical framework, often harbor the same, discriminatory attitudes to traditional practices and practitioners. ‘Western’ education in ‘modern’ health care practices appears to result in these midwives dismissing or devaluing
local knowledge and wisdom. Indeed devaluing other professional or occupational groups is a well-known aspect of ‘professional socialization’. In some settings, midwives have sought or claimed vicarious status, linking their expertise to medicine and distancing themselves from women.\(^{36}\) This mechanism appears to work more powerfully in nations whose health care has been ‘colonized’ and has resulted in actively distancing maternity care from cultural practices that are likely to be positive. For example, teaching TBAs to encourage women to labor and birth on their backs when custom decrees a supported semi upright position.\(^{37}\)

**LIMITATIONS IN THE PROVISION OF SKILLED ATTENDANTS.**
In order to fulfill the IAG call for of providing skilled attendance for all birthing women, an estimated 400,000 midwives would be required to cover the 60 million births that occur unassisted by professional health workers.\(^{38}\) Due to the high rates of illiteracy in rural areas, these midwives would have to be imported from urban centers with additional funding being required to house them, many would need incentives, work for their spouses and education of their children.\(^{38}\) Even where these obstacles could be overcome, other barriers arise. For example, in Indonesia, the training and placement of midwives in rural areas often resulted in placing young midwives without local language or personal maturity and little professional support, in untenable positions.\(^{19}\) Rural based, literate TBAs could become midwives but interfering with the TBAs cultural and social standing (her major attribute and contribution) by changing her professional affiliations, may result in alienating her from the community.\(^{6}\) Furthermore, the current worldwide shortage of midwives exacerbates the problem of providing education systems and skilled attendants for all birthing women, even in Western countries.\(^{24,39}\)

Even when professional services are available, many women continue to access the services of the TBA particularly in the rural areas.\(^{3,19}\) This is because cost, convenience local custom and kindness continue to be the major factors influencing the choice of provider.\(^{40}\) For many rural women the quality of the relationship is more valued than the technical competence of the health care provider.\(^{19}\) Even when trained, most TBAs continue to share the same cultural values and beliefs as the women they serve.\(^3\) They have therapeutic resources known, accepted and expected from the women. They can provide religious and psychosocial support.\(^{41}\)

Women often perceive health professionals as ‘rude, impersonal and arrogant’.\(^{3,5}\) If TBAs know the mothers are going to be poorly treated, they can be reluctant to refer them and if they do refer, the women often refuse to go.\(^{42}\) Western or ‘westernized’ health
professionals can dismiss the importance of cultural values such as privacy or gender of the service provider and subject women to practices considered culturally shameful such as routine vaginal examinations and lithotomy birthing positions. Further factors which influence the women’s decision not to access ‘modern’ health services include long waiting times and the experience, age and gender of the health worker. In societies where wisdom and knowledge come with experience and age, community women often prefer the skills of a senior village woman to a young professional midwife from an urban center.

Models do exist where western trained professionals work well alongside existing traditional birth attendants. Samoa and Malaysia are notable examples where many nurse-midwives are working successfully with TBAs. This successful model is based on collaboration and true partnership in which there is mutual and genuine respect for each other’s skills and practices.

LESSONS LEARNED

Community participation is now accepted as essential to the success of health service programs. The term increasingly appears in many ‘modern’, ‘western’ health care policies, including those of WHO. Professional midwives must ensure that community participation is understood and community input is incorporated into both training programs and health service delivery.

The review of TBA training and resulting shift of focus from ‘trained’ to ‘skilled’ has raised the profile of professional midwifery. Rarely were the skills of midwives acknowledged in the 1970 and 1980 policy documents of WHO and others whereas now these attributes are frequently noted, thus acknowledging the significant role of professional midwives in the provision of maternity services. This recent recognition of professional midwives in the policy documents reviewed for this analysis, appears to be at the expense of TBAs, despite the fact that TBAs continue to be the only support available to many women in the non-western world.

Midwives and policy makers need to redefine ‘knowledge’ to incorporate wisdom and beliefs that exist outside western, biomedical, and professional constructs. By continuing to develop policies within a single worldview we devalue and dismiss the potentially great contribution from TBAs - the biggest maternal workforce in the non-western world. True partnership and collaboration requires the engagement of TBAs locally and recognition of their cultural as well as practical contribution at the highest policy level. The very recent, shift evident in recent policy documentation which is acknowledging and recognizing the
contributions of the TBA in the provision of health services in the non-western world is a hopeful sign.\textsuperscript{23,24,47}

CONCLUSION

The International Confederation of Midwives (ICM) is now a member of the IAG and actively involved in the creation of polices related to the provision of maternity services in non-western countries. ICM is therefore in a position to develop and promote a policy advocating inclusiveness of TBAs rather than persisting with a trend that risks TBAs being systematically excluded in Safe Motherhood initiatives. The ICM can also assist professional midwives in promoting inclusiveness of TBAs as the strategy necessary for effective education and professional practice in many parts of the world. The provision of skilled attendants is an important and worthy strategy in global efforts to save women’s lives. Policy makers need to recognize and respect TBAs and provide wise and informed leadership on this issue. Skilled attendance at birth cannot occur in isolation of birthing systems that are generations old and include traditional birth attendants, trained or untrained. A skilled socio-cultural attendant must have equal recognition to the skilled health attendant. Including TBAs as members of the health service team in policy plans must be more than rhetoric. Policy makers, professional midwives medical practitioners, funding bodies and all others involved in the provision of maternity services must develop collaboration with the TBA that encompasses mutual trust and respect for each other. Only then can we hope to provide improved services and better outcomes for birthing women.
Table One:
Safe Motherhood Action Messages.

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<tr>
<th>1. Advance Safe Motherhood Through Human Rights</th>
<th>6. Ensure Skilled Attendance at Delivery</th>
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<tr>
<td>2. Empower Women, Ensure Choices</td>
<td>7. Improve Access to Quality Maternal Health Services</td>
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<td>4. Delay Marriage and First Birth</td>
<td>9. Measure Progress</td>
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