

Traditional Birth Attendants in an Era of Skilled Attendance at Delivery

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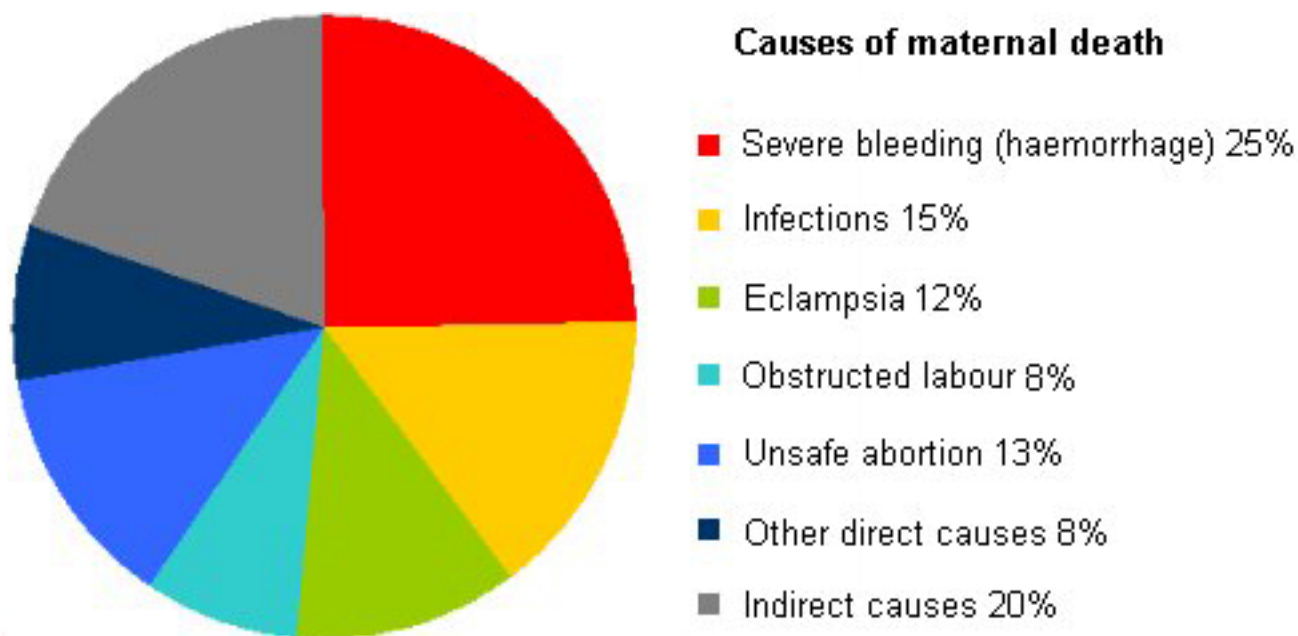
Family Health International

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Causes of Maternal Death



*Source: The World Health Report 2005. Make every mother and child count.
Geneva, World Health Organization, 2005.*

What is Skilled Attendance?

- “Skilled attendance” is defined as “the process by which a woman is provided with adequate care during labor, delivery and the postpartum period” and requires both a skilled attendant AND an enabling environment.

Safe Motherhood Inter-Agency Group, 2000

Skilled Birth Attendant



The term ‘skilled attendant’ refers exclusively to people with midwifery skills (for example doctors, midwives and nurses) who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage or refer complications

WHO/UNFPA/UNICEF/WB

What is a TBA?

A traditional birth attendant is a person who assists the mother during childbirth and initially acquired their skills by delivering babies herself or through apprenticeship to others TBAs

WHO/UNFPA/UNICEF 1992,



Types of TBAs

- Trained and untrained TBAs
- Family TBAs
- Full time TBAs
- Part time TBAs
- TBA/herbalists
- TBA/spiritualists
- Probably other types



Why Train TBAs?

- Too few doctors, nurses and midwives
- Skilled attendants concentrated in urban areas
- Inexpensive to train (per trainee)
- TBA fees are relatively low (financial access)
- TBAs typically follow culturally acceptable practices
- Hold positions of respect in their families/communities
- Even if they can't treat emergencies, they can make referrals
- They can provide other services (e.g., Health Ed, FP, Fe, etc.)
- Opportunity to counter false information and harmful practices

Arguments Against TBA Training

- They are not skilled attendants, i.e, they are not adequately trained or equipped to handle complicated cases
- They mostly attend normal deliveries
- Their real ability to refer in emergencies is questionable
- Sometimes even the referral centers aren't accessible or can't provide good care
- It's very difficult/expensive to establish systems to supervise and supply them on a long term basis
- There are other ways to lower barriers to access/ acceptability
- Value of their performing ancillary services is questionable
- If they aren't effective, they can never be cost effective
- Opportunity costs

Can TBAs Help?

- Causes that TBAs can't do much to influence:
 - Obstructed labor
 - Hypertensive disorders
 - Complications of abortion
- Causes TBAs might be able to influence:
 - Hemorrhage?
 - Sepsis?



Synopsis of the Evidence

- Sibley and Snipe Meta-Analysis
 - There is no compelling evidence that training TBAs reduces maternal mortality
 - There are some modest associations between TBA training and peri-natal mortality – but causality remains elusive.
 - Cost-effectiveness still an issue.

Dilemmas

- Do we want TBAs to attend deliveries or not?
- Absent a role at delivery, what is the motivation for TBAs to engage in new roles?
- Will renewed interest in TBA training undercut the momentum for skilled attendance and again provide a rationalization for delays in providing quality obstetric services ?
- Are there better alternative investments?



My Two Cents

- If maternal mortality reduction is the goal, then skilled attendance should take precedence over TBA training.

Getting to Skilled Attendance

- In transition, the proportion of births attended by TBAs is a key metric but...
....How high is high?



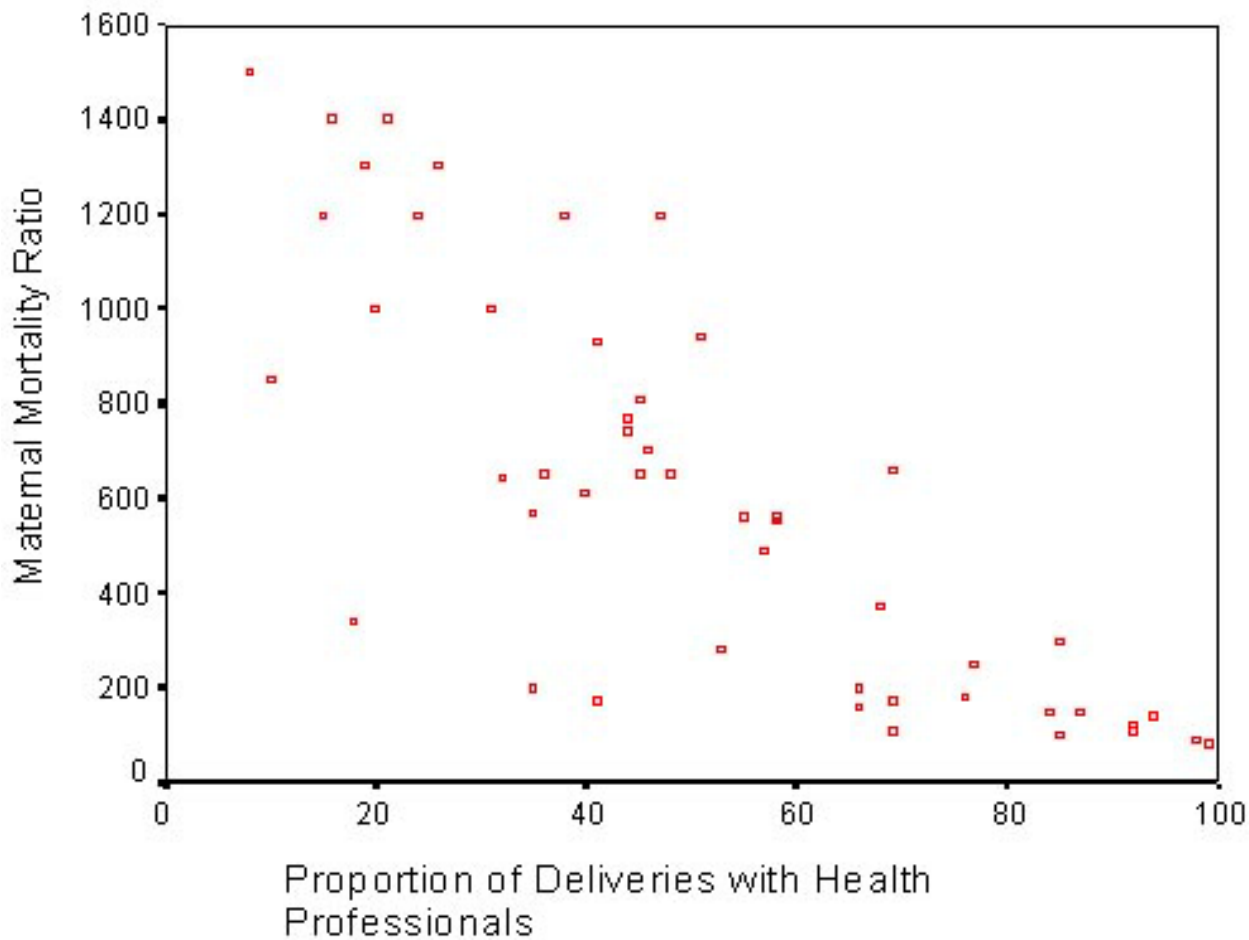
A Common Sense Proposal

- Primary prevention - strengthen family planning as primary prevention of maternal mortality
- Where proportion of births attended to TBAs is “low” (<50%?)
 - abandon TBA programs and focus on health systems strengthening
- Where proportion of births attended by TBAs is “high” (>50%?)
 - Phase Out Approach
 - get started strengthening the health system first
 - Then consider revamped TBA training program as a short term strategy
 - a few evidence-based interventions
 - first aid for selected complications (PPH)

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Proportion of deliveries with health professionals¹ and the maternal mortality ratio² for 50 developing countries, ~1990 W. Graham

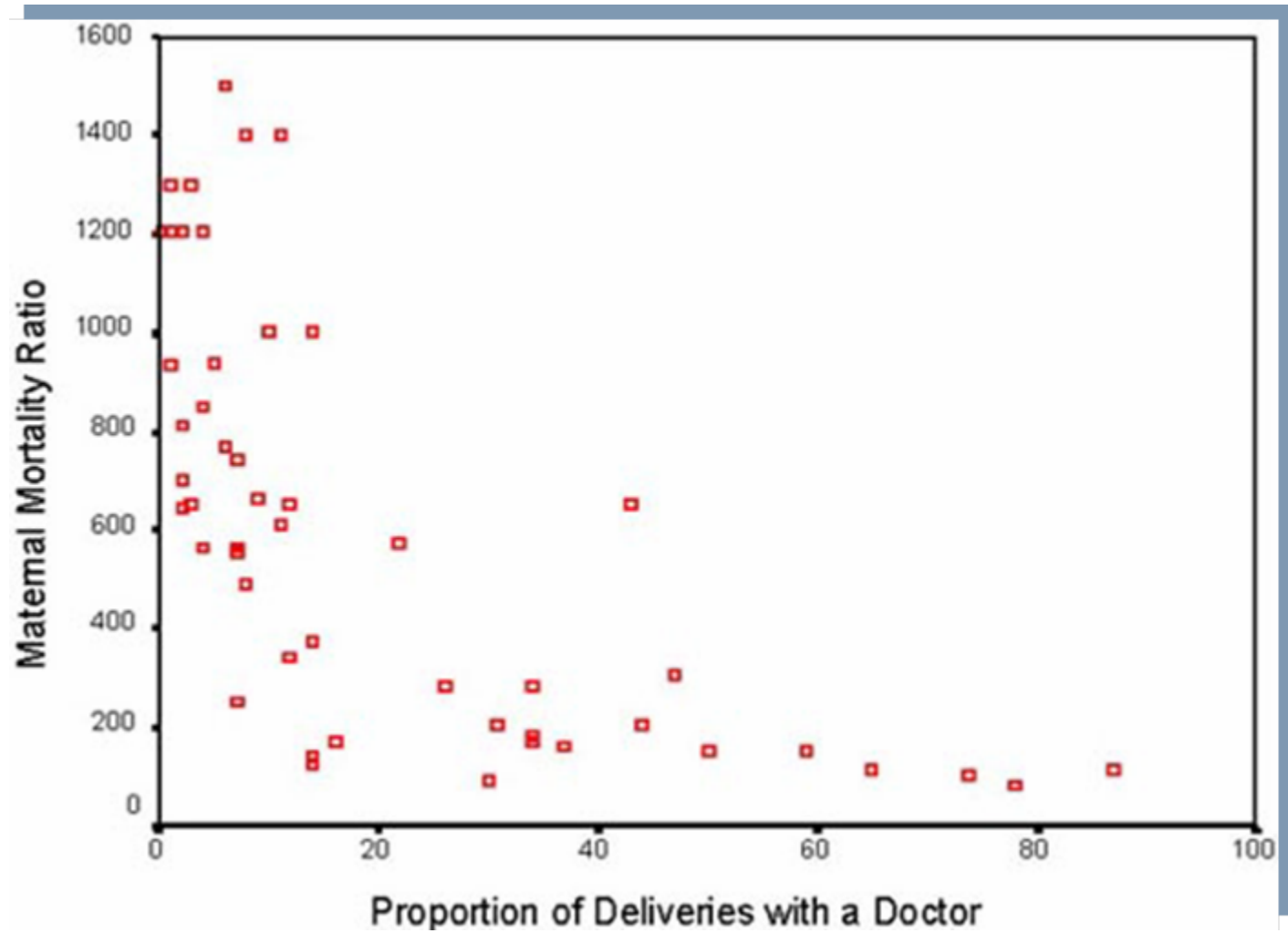


Figure 6. Proportion of deliveries with doctors and the maternal mortality ratio for 50 developing countries ~ 1990 W. Graham

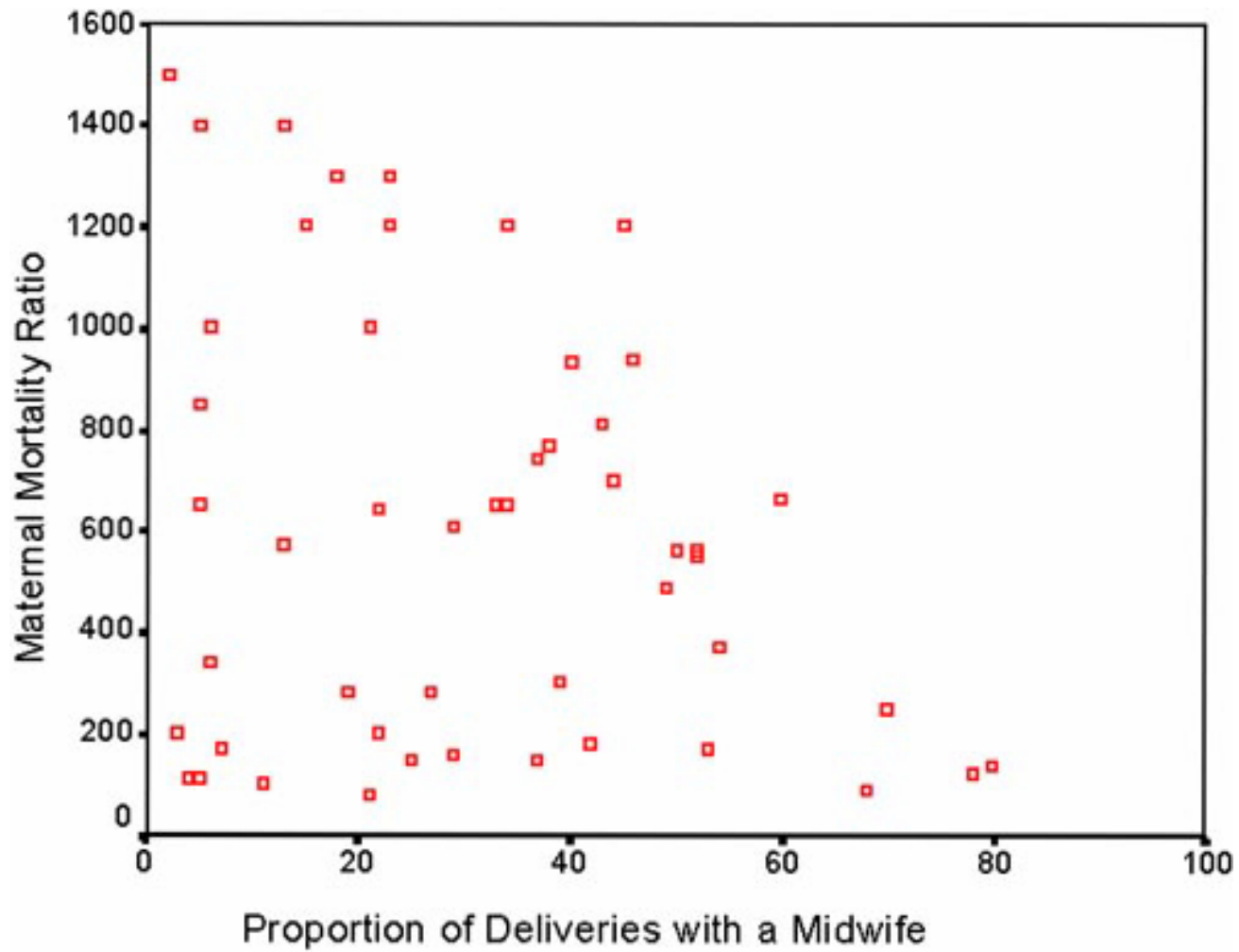


Figure 7. Proportion of deliveries with midwives and the maternal mortality ratio for 50 developing countries, ~1990 W Graham

Millennium Development Goals



- 1. Eradicate extreme hunger and poverty**
- 2. Achieve universal primary education**
- 3. Promote gender equality and empower women**
- 4. Reduce child mortality**
- 5. Improve maternal health**
- 6. Combat HIV/AIDS, malaria & other diseases**
- 7. Ensure environmental sustainability**
- 8. Develop a global partnership for**



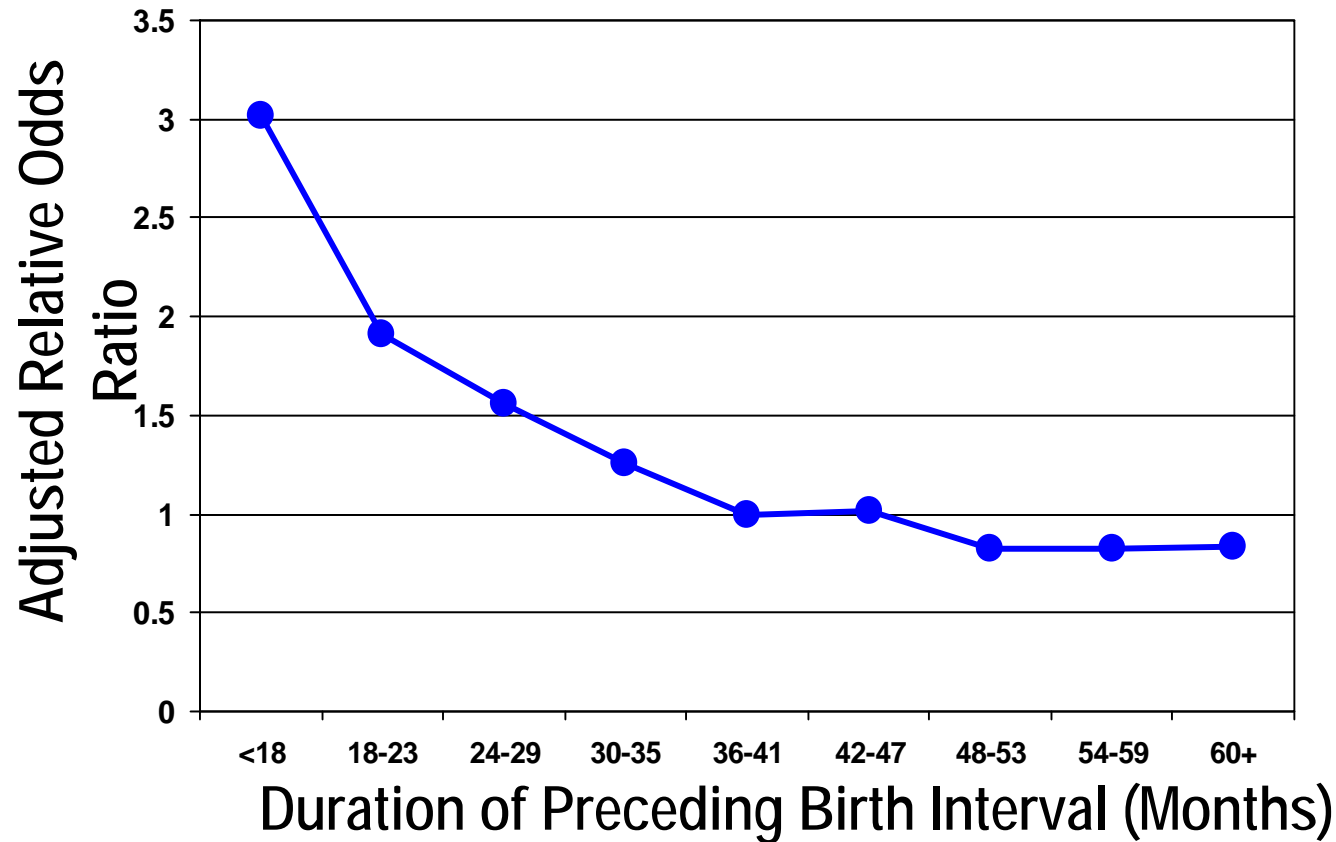


Family Planning Improves Maternal Health

- **Increased use of family planning reduces the absolute number of unintended pregnancies. Reducing unintended pregnancies results in:**
 - Fewer maternal deaths who women try to carry their pregnancies to term
 - Fewer maternal deaths from unsafe abortion
 - Reduced levels of maternal morbidity from

Pregnancy Spacing Saves Lives

Under 5 Mortality by Birth Interval



Source: Rutstein, SO. *IJGO*. 2005;89:S7-S24.

Original Target 5 and Indicators

- Target 5:
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
- Indicators:
 - Maternal mortality ratio
 - Proportion of births attended by skilled personnel



Problems with Original Indicators for Goal 5 Maternal Health

- Both MMR and proportion of skilled attendants only capture experience of women who are already pregnant
(MMR = maternal deaths/100,000 live births)
- Neither captures the magnitude of maternal morbidity, known to be a multiple of maternal mortality

Added Target 5B and Indicators

- Added Target:
Achieve, by 2015, universal access to reproductive health care
- Indicators:
 - Contraceptive prevalence rate
 - Adolescent birth rate
 - Antenatal care coverage
 - Unmet need for family planning





Family Planning Reduces Child Mortality

- Short birth intervals are associated with increased risk of neonatal, infant, child, and under-5 mortality
- Short (< 6 months) intervals between abortions (spontaneous or induced) and the next pregnancy are associated with increased risk of adverse perinatal outcomes
- Family Planning allows families to conserve resources and invest more in the children they do have

FP and Other MDGs

- FP gives women greater educational and employment opportunities, contributing to equality and empowerment, as well as increasing income
- FP enables governments to provide better quality MCH care, education and other social services

