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Integration of Traditional Birth Attendants in Maternal Health Programs

A Case Study in Rural Bangladesh

Introduction

During the Summer of 2005, I traveled to Bangladesh as a Bixby Intern to work with Gonoshathyaya Kendra (GK), a Bangladeshi NGO. My goal was to learn about how training traditional birth attendants (TBAs) can lead to improved maternal health outcomes. GK has been training TBAs, keeping careful records of all their deliveries in the form of birth surveys for at least the past 20 years. These surveys include the location of the delivery, information about who assisted in deliveries, obstetric complications, and many important descriptive variables. My original plan was to travel to GK and set up a database in which this data could be entered. I would then analyze the data to look for significant differences in the outcome associated with the people who attended the delivery and the training level of the attendant. This project was to be completed as part of my master's thesis in the UC Berkeley-UCSF Joint Medical Program.

Once in Bangladesh, however, my goals changed. In addition to analyzing the data, I became much more interested in how GK was able to successfully integrate TBAs into their health programs, both training them to provide basic care and also ensuring a successful referral system. There has been strong debate in the international community about the effective use of traditional birth attendants and whether or not resources should be devoted to their training. It became clear to me that GK successfully bridges the divide

between those who support training and utilizing TBAs in live-saving skills and situations, and those who believe TBAs cannot and should not be used in maternal healthcare.

Background

GK began as a 450 bed hospital set up in a tent during the Bangladeshi Liberation War. The founder, Dr. Zafrullah Chowdhury, left his medical training in England to treat freedom fighters during the war. From there the organization grew rapidly to include a pharmaceutical company, university, printing press, women's support center and many special projects spread out in 10 locations throughout Bangladesh. All of the special projects arose from GK's participation in disaster relief throughout the last 30 years.

A major focus of GK is on its maternal health programs. Their healthcare model is orientated around their "healthworkers" or "paramedics" who are usually young women from low SES families who are trained in one of GK's two training centers for a period of 6-9 months, at which time they go into the community and provide basic health services and advice. They also work alongside government employees on national health campaigns and immunization days. The healthworkers are most familiar with the local villages, the health needs of the people, and work alongside both TBAs and doctors in providing maternal health care

From Data to Description

Upon my arrival in Bangladesh, I was immediately taken to the main GK center in Savar, close to the capitol city of Dhaka. The Savar center has a 5 level hospital,

university, printing press, auditorium and guesthouse and acres of fields and ponds. I was introduced to the health administrators and the research department and attended rounds on the labor and delivery unit.

After familiarizing myself with birth surveys I was planning to enter into my database, I left for the Shreepur training center, where the director of the TBA training programs is located. Once there, I found that there already was a database set up to collect all the relevant health information. Furthermore, the director of the TBA training programs requested that I use qualitative methods in addition to quantitative data analysis for my paper. The data that GK has collected supports the claim that TBAs are doing the majority of the deliveries and GK's MMR of 3.2/1000 is less than half of the DHS number of 6.62/1000 for Bangladesh. This number demonstrates one of the many areas that GK is successful in providing maternal healthcare. Effective utilization of TBAs is main priority of GK and considered a major reason for their success in maternal health outcomes.

My goal for the summer thus changed from analyzing the data to observing TBAs in the field, attending trainings and projects with the healthworkers and studying the TBA training manual developed by GK. I also traveled to other GK sites to observe the different projects that GK has engaged in throughout Bangladesh. Much of my time was spent visiting the satellite centers near the Shreepur training center, where the majority of maternal healthcare takes place.

In my time in Bangladesh, I observed a TBA training in the use of misoprostol, specific hygiene training, and TBAs and healthworkers assisting the government in

National Immunization Week. I also assisted in obstetric emergencies when TBAs brought women to the Shreepur referral hospital.

Towards the end of the summer I began organizing my return trip to Bangladesh, where I plan to observe a TBA training and interview the participants about their background and experience in the training. In relation the current standard set by the safe Mother Hood Initiative of 1997 that promoted only “skilled attendance” at birth, GK is operating under a different model. They have chosen to make TBAs a priority and use them primarily for referrals. The training guide GK has designed stresses skill sharing as opposed to lectures. They believe that obstetric emergencies are nearly impossible to treat in the absence of an equipped medical center.

Thus in many ways GK bridges the gap between those who believe TBAs can and should be trained in life saving skills and those who do not promote their use at all. From the rough analysis I was able to perform on their data, it appears that they are quite successful in preventing maternal mortality and obstetric complications. I hope that my further analysis of GK’s maternal survey data and TBA training will be published and can serve as a case study of the successful promotion and use of TBAs in an effective health program.