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Implementation of Partnership between Midwives and Traditional Birth Attendants Inkotabaru District

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Abstract

Background: Maternal and infant mortality ratio, in the Kota Baru high enough, one of them because of labor that much by the Traditional Birth Attendants (TBA). Midwives offer fewer deliveries and coverage has not reached the 95% target and fewer midwives than TBA.

Objectives: This study aims to know the implementation of the partnership program between midwives and traditional birth attendants in Kotabaru District.

Method: This study use da qualitative approach to the design of case studies, with purposive sampling technique. The number of the main informant as much as 3 people and informant triangulation 6 people. This research was conducted for 1 month consists of content analysis and data processing.

Results: The results show human resources are still lacking, inadequate facilities and funding partnership that is often paid late. Midwives and TBA is not made a written agreement, and over the role of the TBA will not be in accordance with there gulations. The support from the village head and community leader that there is no information and the number of TBA partnering is still less.

Conclusion: Our findings conclude the importance of cross-program coordination and involvement in the District Health Office and across sectors at the District Government level. This participation is urgently needed from local stakeholders playing a major role in the successful implementation of maternal and child health programs.

Keywords: Midwives; traditional birth attendants; implementation of partnerships.

Introduction

Traditional Birth Attendant's (TBAs), "dukun beranak" in Indonesia, has been around for a long time, and are still practicing labor and childbirth, where most deliveries occur at home and are not assisted by skill birth attendant such as midwives. This situation increases the risk of death for the mother and her baby.¹ TBA is a trusted employee in the family and community in all matters relating to women's reproductive problems and their work is obtained from generation to generation.² Indonesia, which has a variety of tribes, customs, and cultures in the community, they are considered capable of providing emotional comfort and security to mothers during pregnancy check-ups, assisting mothers and caring for their mothers and babies after birth for up to

40 days. TBA's knowledge of pregnancy and birth is so lacking that if complications arise they are unable to overcome them even realize it.³ However, in addition to providing technical assistance, TBA also practices unsafe abortion and contraception at high risk and threatening the life of the pregnant woman.⁴

Family TBA is someone who has been appointed by a large family to attend a birth in that family. Trained TBAs are family TBAs who have received short training courses through the modern health care sector to improve their skills.⁵⁻⁶ So, starting in 2007, the government initiated a partnership program by village midwives and traditional birth attendants aimed at reducing maternal and child mortality and morbidity.⁷ This statement reveals that the higher the number of

deliveries assisted by TBA, the more high risk that will potentially endanger the safety of the mother and baby. This is because the traditional birth attendants do not have enough ability and knowledge to handle obstetric complications and emergencies (EMOC) that occur during and after labor.⁸ Then, between midwives and doulas, they offer physical, emotional, and ongoing support while simultaneously encouraging patient autonomy. However, disagreements between them also occur from the Middlemiss study in the UK, differences in the role of doulas and midwives and identify potential for conflict if the role of doulas is misunderstood. Some experts have identified antagonistic attitudes towards doulas that create challenges for midwives⁹ and lead to inter-professional conflicts in the dynamics between midwives and doulas.¹⁰ In Canada, this misconception, midwives and nurses fear that doulas will take over their roles and "grass" jobs.¹¹⁻¹²

Death that occurs in a hospital is a referral for labor handled by TBA. Furthermore, in some cases TBAs called on midwives when their mother's condition was severe. At this time, there are 329 TBAs in Kotabaru District. Their presence is spread in 21 sub-districts. Meanwhile, only 220 midwives served. The coverage of childbirth assistance by health workers is 68.2% which has not increased and has not reached target 95% from 2014 to 2017.¹³ Based on this problem, this

research is intended to know the implementation of the partnership program between midwives and traditional birth attendants in Kotabaru District.

Materials and Method

The study design uses an explorative qualitative approach. A total of 9 participants consisted of 3 village midwives and 6 triangulation informants. This study was conducted at the Berangas Public Health Center in Kotabaru District, South Kalimantan Province. The selection of research locations was taken through considerations, among others: First, coverage of delivery assistance by health workers in the last 3 years had not met the District target of 95%. Second, their have the highest number of traditional birth attendants from the number of midwives. And, third, their has an ongoing partnership program indicator.

Data collection uses in-depth interviews, and semi-structured interview guides. Processing data with content analysis. The aspects studied include the system of implementing partnerships, namely 1) Human Resources, funding, facilities, and data collection and mapping of traditional birth attendants; 2) Fostering of traditional birth attendants; Written Agreement for Midwives and TBA; and the role of TBA; and 3) Support of Village Heads and Community Leaders.

Results

Characteristics of Participants

Table 1: Characteristic of Participant

No	Code Informant	Age	Sex of Gender	Education Background	Work Status	Period of Work
Main Informant						
1	IU 1	28	Female	Midwifery Diploma	Midwife of Berangas	Six years
2	IU 2	28	Female	Midwifery Diploma	Midwife of Sungai Limau	Three years
3	IU 3	29	Female	Midwifery Diploma	Midwife of Batu Tunau	Seven years
Triangulation Informant						
1	BK	39	Female	Midwifery Diploma	Coordinating Midwife	21 years
2	DB	55	Female	No school	TBA Partnered	Five years
3	DT	70	Female	Primary School	TBA Not Partnered	30 years
4	TM	47	Male	High School	Community Leader	20 years in village
5	KD	49	Male	High School	Village Head	Three years
6	M	29	Female	Primary School	Mothers is served by Midwives and TBA	Second Labor

Analysis of Results

Human Resources: Thirteen midwives were obtained: 1 coordinating midwife and 12 other midwives serving in the village and in the puskesmas who were also double the task of fostering villages that did not have a midwife. From the interviews, information was obtained that 1 midwife served 2 to 3 villages at a time, because other villages that did not have midwives to cover all villages in their work area.

"..Serving three villages, meaning one village has three regions: Rampa Kapis, Batu Tunau and the Coal Mining Company." (IU2) "Each place only has a few empty villages" (IU1, IU3)

Interview for six triangulation informants, we obtained a statement that three midwives were still not living in the village but were willing to come at any time if needed.

"..do not live in the village every day, if called they are willing" (KD, M) "there is no residence in Berangas village, but if anyone wants to give birth, they are ready to come" (BK)

Half of the midwives, residing in districts and villages, have areas with a geographical area that vary by a distance of 25-30 km.

"I live in urban areas for about 30 minutes from Berangas Village because my children go to school in there" (IU3) "..back and forth to the village, but don't stay overnight" (BK, M)

Midwives as MNH service providers and partners in implementing partnerships still lack adequate capacity. In terms of management, there are still two villages that do not have midwives. They also caseload to serve other programs. Type of inpatient health centers located in isolated areas.

Facilities and Infrastructure: Access and difficult terrain is also an obstacle. It must be taken on foot. Medical equipment is very unnoticed, so they add unsafe ingredients to the baby's umbilical cord.

Funding Source: Specific funds for partnerships do not exist. Companion funds come from Health Operational Assistance (BOK). The funds according to them are insufficient because they are considered too little. Disbursement of funds is not routine every month but has to wait a long time.

Written Agreement for Midwives and TBA:

Information from two people revealed never made a written agreement. Only an oral request to call the midwife if there is something

"..nothing.. we just talked.." (IU1, IU2)

Even they do not know the information about the partnership. the coordinating midwife stated that the agreement had not been made, it was still in the planning stage and had not been implemented.

"..up to now has not been implemented, because many other health programs take precedence" (BK)

TBA will call the midwife, if the baby has been born and delivery has been completed just to cut the baby's umbilical cord.

"..because I am not allowed to cut the umbilical cord with a knife and concoctions" (DB)

Fostering of TBAs: Fostering shamans only through refreshing once a year and not all of them are invited. Midwives provide guidance on useful knowledge.

"Guidance and refreshing shamans have been carried out ..This year is only once, this year just once" (BK, TM)

Different from the 3 other triangulate informants who claimed to have never known and were never invited to refreshing the shaman.

"..never really meetings, try to be invited to meetings" (DB, DT, KD)

The Role of TBAs: Only one midwife informant who collaborated and applied the transfer of roles with TBAs.

"..if at my place, TBA tells me that pregnant women will give birth.. we usually join together to help until parturition " (IU1) "they usually massage, make herbal concoctions, and midwives care." (IU2)

Other different information TBAs are not partners, refuse cooperation and complete change of role. Only ever accidentally help together give birth.

"..Ever..she only held the abdomen, if part of the birth ..of course midwife"(IU3)"..Postpartum mothers still visited by midwives." (BK, DB, M)

Midwives and TBAs seem to compete and look less harmonious. *"...they (midwives) hold mother's full ..if her signs of birth appear, you call me, I better go home"* (DT)

it can be concluded that TBA not partnered still does not work together so that their role is still helping birth and the baby independently.

Support of Village Heads and Community Leaders: Real support was provided from the village head and community leaders, but information about the partnership program was not yet optimal. During this time they made requests to give birth with midwives at the health center.

Discussions

Human Resources: Resources hold an important influence in the implementation of health care systems, especially partnerships. Resources include implementing personnel, infrastructure, service facilities, and funding. Midwives are competent health workers who are stationed and should reside 24 hours in the work area of the puskesmas.¹⁴ One of the factors that caused the community to choose to be assisted by a dukun is the distance between the community's house and the dukun in the adjacent village and the TBA is always 24 hours. While many of the midwives reside in areas farthest from the reach of the community.^{1,7}

Facilities and Infrastructure: Geographical conditions make it difficult to call midwives so that pregnant women choose TBA who are domiciled around their homes.¹⁵ To be able to realize the partnership, childbirth must be assisted by midwives, the government must be able to facilitate adequate health facilities and ensure the availability of quality midwives in each village and easy access to services.^{16,17}

Funding Source: The availability of a budget plan for the Birth Waiting Home which is a temporary residence for pregnant women who will give birth until the postpartum period including their babies and their companions (husband/family/cadre)⁶.

Written Agreement for Midwives and TBA: A written agreement between the midwife and the dukun is made together, in accordance with the implementation manual which contains information on the mechanism of reference for pregnant women, the referral mechanism for labor cases, the mechanism for distributing labor costs and the schedule for regular meetings. In line with

the results of research by Rochmayanti the partnership did not go according to expectations and targets despite having a memorandum of agreement between them¹⁸

Fostering of TBAs: TBAs are also not equipped with knowledge of detection of danger signs in pregnant women, maternity, postpartum and newborn babies as well as ways of referring midwifery. In terms of benefits, some TBAs want to follow the call so that they don't help their own deliveries anymore. But the appeal is not optimal so that they are still many who help deliveries unsafe.¹⁹

The Role of TBAs: In the period of childbirth: remind the family to prepare transportation to the midwife, prepare safe delivery facilities such as clean water and clean cloth, and accompany the mother when giving birth. Some things in the puerperal period are: making home visits and motivating mothers to use contraception after giving birth, and motivating referrals if needed and reporting to midwives if the prospective acceptor wants to use contraception.²⁰

Support of Village Heads and Community Leaders: The support of community leaders is needed in collaboration between midwives and TBAs. This support includes socialization and direction through village meetings, mediation between midwives and TBAs and helps influence other parties such as posyandu cadres, village officials, and TBAs to take an active role in the partnership.^{21,22} Some other village heads did not yet know information about the program.

Conclusions

Some obstacles in implementing the partnership program are midwives and TBAs on the utilization of SBA and strengthening the role of each available resource. Funding management from Jamkesmas, DAK and other fund allocations needs to be maximized so that the community realizes that safe delivery with midwives and in health facilities is accompanied by TBAs, not obstacles or concerns from families and communities. Training of skilled TBAs needs to be considered as a refresher in the skills of their childbirth practices under the supervision of the District Health Office, the priority of areas that are difficult to reach.

Conflict of Interest: None

Ethical Clearance: Obtained from university committee.

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