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REPRODUCTIVE HEALTH IN DEVELOPING COUNTRIES

**Fertility Regulation through Traditional Midwives
along the Thai-Burma Border**

By

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Thesis submitted in partial fulfilment of the requirement for the
Reproductive Health Course
July 2006

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SUMMARY

Multiple confounders with important interaction make a cause & effect analysis difficult when discussing factors contributing to decrease reproductive mortality. Every sector taken up to be improved is a step towards the objective of improving women's well-being.

Findings of this literature review are: traditional midwives (TMs) as contraceptive distributors are not significant in reducing reproductive deaths. The main killer among mothers in Burma and along the Thai-Burma border is unsafe, septic, induced abortion.

Even if TMs cannot provide emergency obstetric care, as distributors of modern contraception they could affect the maternal mortality in four ways.

- 1▶ Reducing number of pregnancies, which decreases the number of times women face risk of maternal death.
- 2▶ High-risk pregnancies at higher parities can be avoided.
- 3▶ Women can avoid unwanted pregnancy, which may end in unsafe abortion or in not seeking care or in abandoning a baby.
- 4▶ Involving TMs in contraceptive services may replace their practice of inducing unsafe abortions.

As long as most of the deliveries are still at home with indigenous midwives maternal mortality can not be reduced below 100/100,000, even if there is functioning emergency obstetric care (EmOC) available. Examples from Brazil and China have shown this¹.

It is still realistic that the present high mortality from over 600/100,000 in Burma's internally displaced people (IDP) areas can be significantly reduced.

Fertility regulation is not a substitute for obstetric care in a limited budget country, but they should work together.

TMs have been utilized in some countries by integrating them successfully into existing health systems. Even in countries with political stability the reduction of maternal mortality took decades. In an unstable population disrupted by civil war additional factors delay the process.

To overcome the feminization of poverty girls schooling is to be promoted. The number of girls in secondary schools needs to be increased, so that the coming generation has a better understanding of health issues.

No RH prospective intervention studies about postemergency settings with TM programmes for fertility regulation have been found in the literature.

There cannot be one monopolized concept for healthcare or for safe motherhood, or for population stabilization. We need measured tailored projects for every ethnic group in its circumstances reaching each needy individual. If one way does not bring the expected results, the strategy must be changed. With motivated skilled midwives from the Backpack Health Worker Team (BPHWT) and additional trained EmOC-staff, who can form a link in a transition period until there are enough literate skilled midwives, as many lay midwives as possible should be offered training on a voluntary basis with as many skills as they can take in.

Disarmament of rebel groups and peace negotiations are essential.

ABBREVIATIONS

BPHWT	Backpack Health Worker Team
BEmOC	Basic Emergency Obstetric Care
CBD	Community-Based Distributors
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
EC	Emergency Contraception
EmOC	Emergency Obstetric Care
FP	Family Planning
GHAP	Global Health Access Program
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ICD-10	International Classification of Diseases (10 th revision)
ICPD	International Conference on Population and Development
ID	Internally Displaced
IDP	Internally Displaced Person, Internal Displaced People
IPD	Inpatient Department
Lao PDR	Lao People's Democratic Republic
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MTC	Mae Tao Clinic
NGO	Non-Governmental Organization
PAC	Post Abortion Care
PHC	Primary Health Care
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TM	Traditional Midwife
TFR	Total Fertility Rate
TL	Tubal Ligation
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WCRWC	Women's Commission for Refugee Women and Children

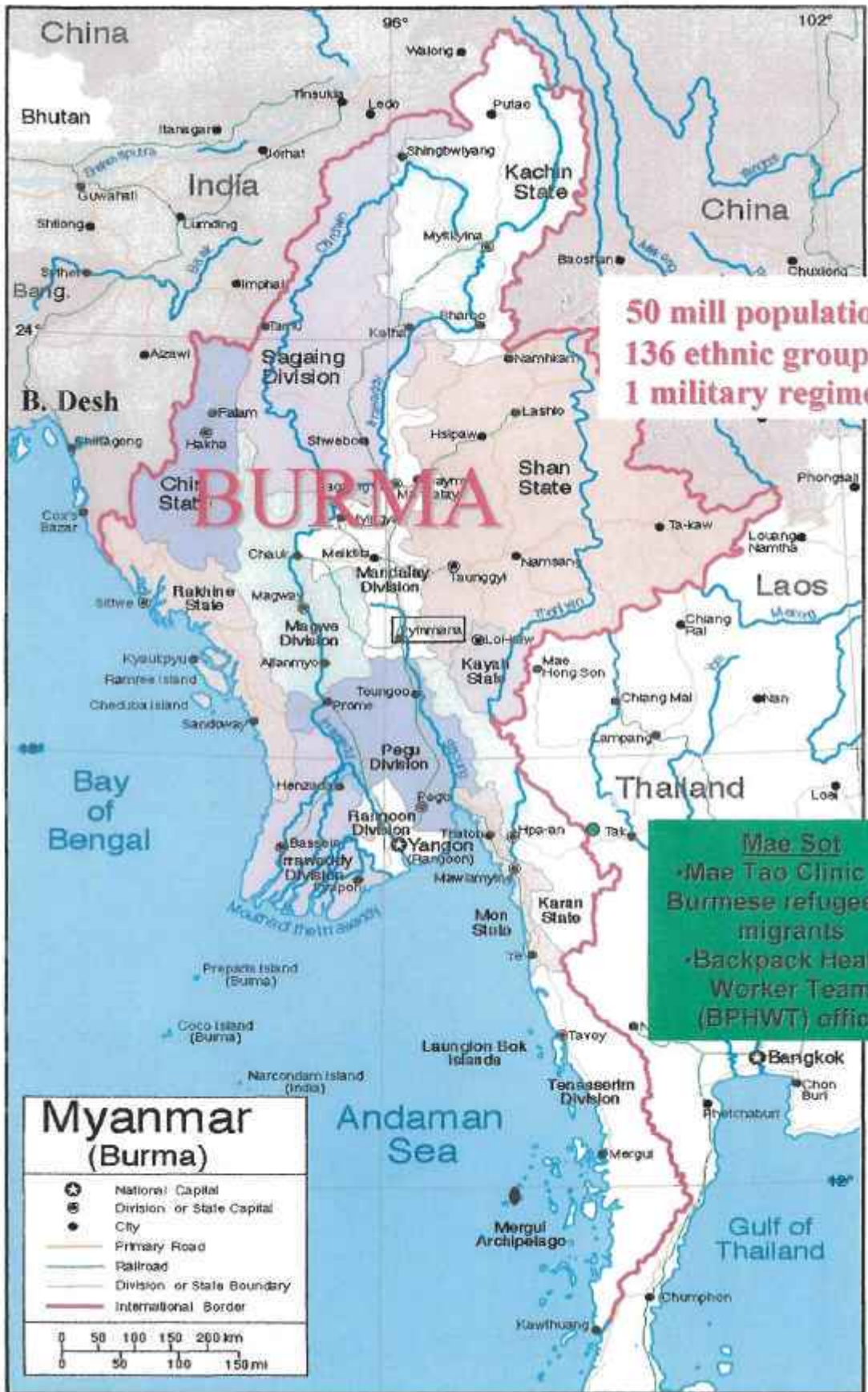
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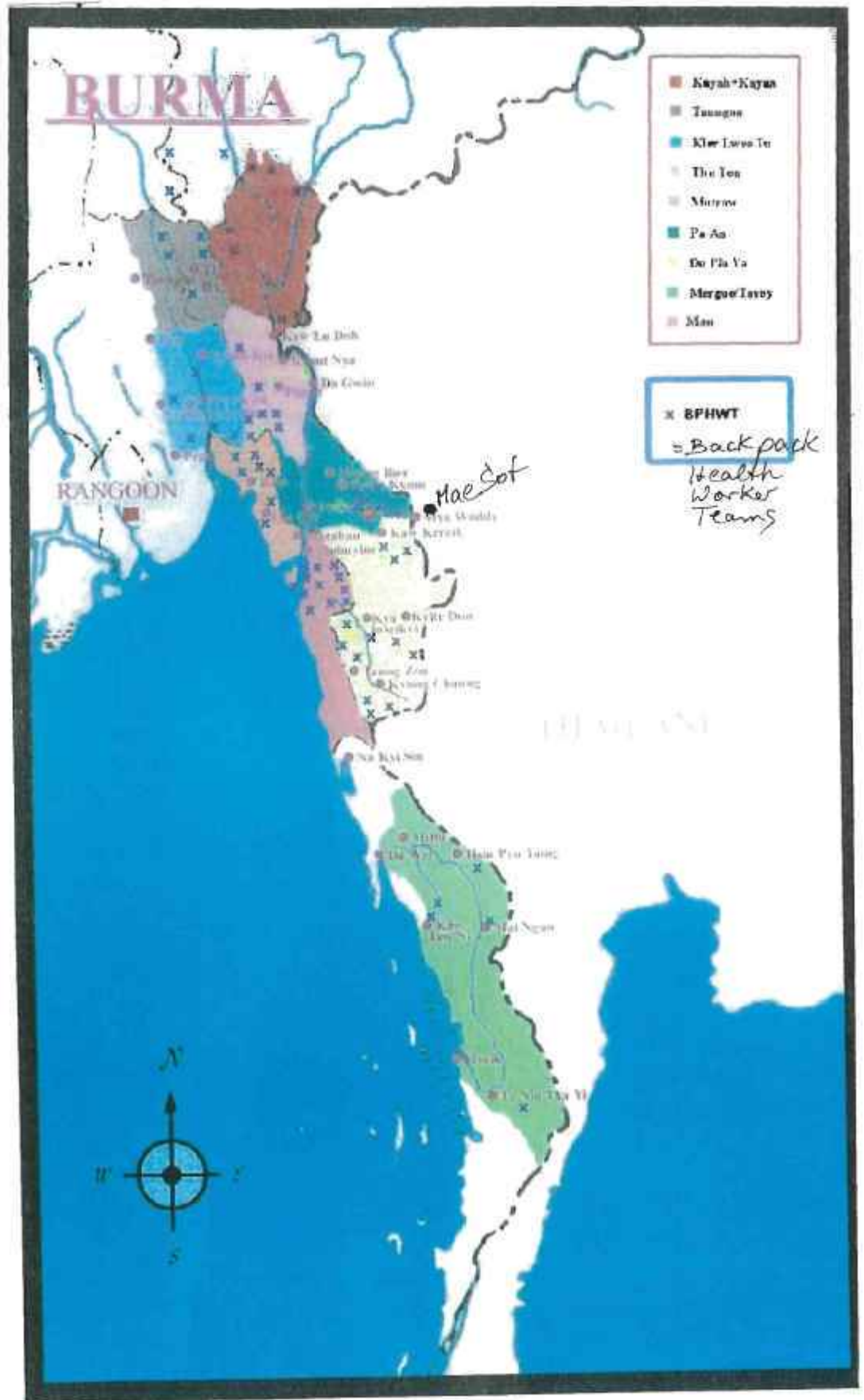


Figure 1 Internally displaced people or refugees?
Moving back and forth across the Thai-Burma border.



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The shift of the capital to Pyinmana in 2006 produced hundreds of forced migrating families.



INTRODUCTION

MATERNAL MORTALITY AMONG BURMESE REFUGEES, MIGRANT WORKERS AND INTERNALLY DISPLACED PEOPLE (IDP)

The country

Burma* (population 50.5 million)² has been in civil war since 1949.

Fighting between separatist ethnic rebel groups and a suppressive military junta has uprooted about two million people. Internally displaced people often have no access to schools and basic health services. Eastern Burma shares a border of 1800 km with Thailand³. The mountainous border area is populated by ethnic groups: Shan, Karenni, Karen and Mon.

About 500,000 Burmese refugees and migrant workers live in Thailand, many of them are unregistered, being 'illegal' in both countries⁴.

Refugee camps have existed in Thailand for over 15 years. The Burmese army has crossed several times the border river to burn down refugee camps^{5,6}.

* After a bloody crackdown with thousands of peaceful demonstrators being shot down in August 1988 the military authorities have promoted the name Myanmar as a conventional name for their state. This decision was not approved by any legislature in Burma. Aung San Su Kyi, the winner of legislative elections in 1990 is under house arrest. Her Nobel Prize for peace (1991) could not change her imprisonment. The suppressed Burmese population refer to themselves as Burmese. In this thesis data used from the government are referred to as Myanmar. Data before the official name change are mentioned under the previous name Burma. Data from IDP and Thai-Burmese border are referred to as Burma and Burmese.

Health services

Along the eastern border inside **Burma** there are only a few government hospitals. For some IDPs due to lack of roads, fuel or money the nearest hospital is up to 2 days walking distance away. Myanmar government hospitals are not free, and patients are turned away if they can not pay.

Thailand has an efficient health system from health centres to district hospitals, which gives all Thai registered patients free access to all services for 30 Baht* entry fee. Unregistered Burmese have to pay the full price and risk being arrested as they are illegal in Thailand.

Refugee Camps are under the United Nations High Commissioner for Refugees (UNHCR) with international non-governmental organizations (NGOs) providing health services. Thai hospitals serve as referral hospitals, funded by foreign aid organizations.

In 1989, Dr Cynthia Maung, a refugee herself, established the **Mae Tao Clinic (MTC)** in Mae Sot, Thailand, 4 km from the Burma-border. In following years branch clinics in the insurgent area were founded. Burmese refugees are trained as medics to deliver health services as mobile medical teams inside Burma. The MTC has grown into a comprehensive community health centre with 120 beds, currently serving 49,000 patients per annum.

* 30 Thai Baht = GBP 0,42 or Euro 0,62

The clinic runs outreach services for migrant workers, supports schools and cooperates with exiled ethnic organizations. The status of the MTC is still not legalized in Thailand, but well tolerated from the Thai Government Hospital in Mae Sot, to which patients are referred if necessary.

In 1998 the mobile medical teams organized themselves into **Backpack Health Worker Teams (BPHWT)**, now consisting of 70 teams, each with 2-5 health workers reaching a total population of 140,000 in scattered remote jungle settlements. Twice a year the BPHWT return to Mae Sot to restock their supplies.

The MTC and BPHWT are funded by international friends and NGOs.

In 1998 the MTC began training traditional midwives (TMs) as a strategy to reduce maternal mortality among IDPs.

A preliminary survey in 2001 showed that about 90% women in the area in which BPHWT worked delivered at home or in the jungle and less than 5% had access to emergency obstetric care⁷.

For 15 years I have been working in the Mae Tao Clinic every winter as a volunteer, teaching primary health care (PHC) medics, upgrading maternal and child health (MCH) medics in midwifery skills and improving services through BPHWT and traditional midwives.

Maternal Deaths

Table 1 How big is the problem?

	MMR	Year
Thai national data⁸	20	2003
<u>UN data for Thailand⁹</u>	44	2003
<u>Burma¹⁰</u>	580	1996
<u>Burma hospital data “model based”¹¹</u>	360	2000
	‘During-Delivery-MMR’	
<u>Mae Tao Clinic¹²</u>	354	2005
<u>BPHWT area¹³</u>	559 - 954	2001 - 2004
<u>BPHWT estimate^{12,13}</u>	1,200	2005
<u>Mutraw (Papun)¹⁴</u>	1,930	2005

- The estimated maternal mortality ratio (MMR) for Thailand is between 20 and 44 per 100,000 live births.*
- For Burma estimates were between 91 to 660, with a model based MMR of 360**11,15.
- Living in between both countries, Burmese refugees and IDPs have higher MMR. In some areas with frequent displacement e.g. Kaw Kreik 35% of the women had to deliver in the jungle¹⁶.
- It is difficult to get estimates as deaths during pregnancy or postpartum are not recorded. Illiterate TMs can not count 42 days postpartum. The real figure for MMR is likely to be higher.

* The discrepancy comes, because refugees, migrant workers and some ethnic groups without Thai national status do not enter national statistics. Still an arguable human right issue.

**Present MMR statistics of Myanmar are limited to data collected from hospital records, but 80% of deliveries are at home and 32% are with skilled attendant.

Causes of maternal death

AbouZahr emphasized the importance of analyzing each case of maternal death rather than calculating MMR¹⁷.

In our situation 2 days walking to the next hospital, 8 hours to the next BPHWT is not uncommon. A main cause of death globally is lack of access to hospitals^{18,19}.



Figure 2 Patient transportation: 8 hours walking to the next health care team

Maternal death reviews from Mae Tao Clinic revealed in 2005 unsafe abortion was the main cause. Two out of five deaths were related to complications from induced abortion: a mother of 6 living children, aged 35 and a mother of 5 living children, aged 34¹². Analyzing post abortion care (PAC) data from RH IPD show that they are mostly grand multigravidas that undergo abortion□.

* In 2004, out of 439 admitted abortion complications were 94 primiparas, 147 had two or three pregnancies, the majority of 198 had 4 or more pregnancies.

Table 2 Mae Tao Clinic: services provided and admissions

	1998	1999	2000	2001	2002	2003	2004	2005
Deliveries	352	356	489	769	961	1413	1639	1520
Complications of abortion*	219	277	213	260	297	341	439	433
Family Planning visits	643	1503	2376	3723	3966	6469	7534	6948
% Abortion per 100 deliveries	62,2	77,8	43,5	33,8	30,9	24,1	26,7	28,4

Together with a tenfold increase of FP visits in the last 8 years it was noted that the proportion of abortion complications versus deliveries has decreased significantly. 77.8 post abortion complications admitted versus 100 deliveries in 1999 fell to 28.4 in 2005. The incidence of (unsafe) abortions per 100 live births is used as an indicator^{20,21}. About one quarter to one third of all admitted women for PAC are diagnosed with unsafe, septic or induced abortion^{22,23}.



Figure 3

Unmet need for Contraception

* Number of patients admitted to Inpatient Department (IPD) for PAC including spontaneous and induced abortions.

Unmet need for contraception*²⁴

A BPHWT survey¹⁶ from 2002 among 1,169 ID women found 10% reported at least one induced abortion and 18% did not respond or not know. Of the induced abortions, 17% were self-induced, 34.8% were through a TM, 31.8% did not know and 6.3% gave no answer.

59.8% of those not wanting any more children did not use contraceptives. Reasons were fear of side effects (15.3%), expense (10.4%), religion (5.6%), husband's objection (7.3%), and breastfeeding (21.9%).

Among IDPs interviewed most were illiterate, 85.2% unaware of the ovulation cycle, 10.4% used Depoprovera**, and 8.9% the contraceptive pill.

The report shows that early marriage and adolescent pregnancy is common, with over two-thirds of youth married by 20 years of age and more than a fifth of girls having reported their first pregnancy by 18 years.

In Mutraw area (population 16,000) with the highest maternal mortality (6 deaths in 306 deliveries) contraceptive prevalence is almost non-existent: in 2005 only 31 family planning (FP) visits were reported¹⁴.

In this thesis I will explore whether the traditional midwives can be converted from unsafe abortion inducers to contraceptive promoters and distributors. I believe that if women have a choice they choose contraception not abortion²⁵.

* 'Unmet need' is defined as the percentage of married women not using contraceptives and not intending to get pregnant. Women not in stable relationships, who use traditional methods and want to switch to modern methods, or who want to change from child spacing to child limiting, or who are dissatisfied with their current contraceptives have an unmet need too. They do not currently occur in the statistics.

** Depot medroxyprogesterone acetate injection

LITERATURE REVIEW

Through literature research (hard copies, electronic database Pubmed, RH-websites, and references from peer reviewed journal articles) I hope to find new approaches on how to make the best use of TMs and how to harness them for fertility regulation. It is also an opportunity to update myself on the role of traditional midwives in general.

For this thesis articles from geographically or culturally related countries and projects were chosen, except one from Guatemala, where the unique initiative by a midwife was of interest. Criteria used for success are contraceptive prevalence rate (CPR), total fertility rate (TFR), maternal mortality ratio (MMR)²⁶, keeping in mind Dixon-Mueller's statement that CPR and TFR can not tell us about the effectiveness of contraception, those indicators rather show an interaction with MMR²⁷.

Three different projects are reviewed from Lao People's Democratic Republic (PDR). For easier referring they are introduced as Lao (I), Lao (II) and Lao (III).

No limitation was drawn to the year of publication since the setting on the Burmese border is decades behind neighbour countries. Special interest is given to the introduction of FP programmes in Southeast Asia, because similar problems may be faced with initial implementation of fertility regulation programmes among Burmese IDP.

KEY QUESTIONS FOR THIS LITERATURE REVIEW

- ◆ Can fertility regulation reduce induced abortions and maternal mortality?
- ◆ What is the role of TMs in agendas and discourses?
- ◆ Where did and do TMs provide contraceptives? Is that effective? Are other countries' TM programmes replicable for the IDP population in Myanmar/Burma?
- ◆ How to train illiterate TMs in FP?
- ◆ Can the TM concept work among IDPs, refugees and “illegal” immigrants?

SEMANTICS

From Family Planning to Fertility Regulation

Using Pubmed to search for peer reviewed journal articles, a shift in nomenclature was found. The keyword ‘family planning’ showed only 1988 entries, mostly before 1990. The term ‘fertility regulation’ occurred in 5855 newer publications. This thesis leaves the antiquated term ‘family planning’ therefore aside.

From Traditional Birth Attendants to Traditional Midwives

In the literature the terms 'traditional birth attendants' (TBAs), 'traditional midwives' (TMs), birth attendants with midwife skills' (BAMS)²⁸, and 'skilled attendants' are all used. The more respectful term 'traditional midwife' is used in this thesis, because her function within the community is not related only to birth. Solidarity projects and individual authors recognize the work of those practitioners as midwifery work and suggest the term 'traditional midwife' is preferable to the narrower reductionistic 'traditional birth attendant'^{22,29,30}.

In the anthropologist and social science literature the term 'traditional' is questioned, because it is coined by the international development establishment and positions them "as the locus of authoritative knowledge while devaluing other, local forms of knowledge". In development discourses it is questioned whether health development can achieve their high set goals within the present conceptual framework³¹.



Figure 4 Taunggyi, Burma Too early, too close, too late, too many

FERTILITY REGULATION IS THE MAJOR PREVENTIVE HEALTH CARE MEASURE TO REDUCE MATERNAL MORTALITY³²

Contraceptives are effective and safe means to improve women's health.

A WHO goal is "access by all couples to information and services to prevent pregnancies which are too early, too closely spaced, too late, or too many"³³.

- Annually about 600,000 women die from pregnancies and 15 million women suffer from disabilities resulting from pregnancy and childbirth³⁴.
- High fertility levels are correlated with high maternal mortality³⁵.
- Each year more than 75 million pregnancies are unwanted³⁶.
- 22% of all pregnancies end in induced abortion³⁷.
- Worldwide unsafe abortion causes 13% of maternal deaths³⁵.
- Unwanted pregnancy is a risk factor for less prenatal care and skilled attendance.
- Child limiting wish comes from older multigravidas, a risk factor in itself.
- If women could prevent unwanted pregnancies, about one quarter of maternal deaths could be prevented. Access and use of contraceptives could save worldwide 150,000 lives per year³⁸.
- "Promoting family planning is a sure way to reduce unsafe abortions; if every woman who wished to delay or limit births made use of effective contraception, maternal mortality would drop, worldwide, by an estimated 17 to 35 percent"³⁹.
- The combination of high TFR, high MMR and resource-poor settings are evident when comparing developing regions with a probability of maternal death of 1 in 61 versus women in industrialized countries (1 in 4000)⁴⁰.

IN MYANMAR (BURMA) ABORTION WAS AND IS THE MAJOR CAUSE OF MATERNAL DEATHS.

Abortion is a serious public health problem in Myanmar. The situation has not improved in the past 30 years. In 1975 the country profile shows 48.6 abortion admissions per 100 deliveries, in some regions even 77.3 per 100 deliveries⁴¹. In 1980 the CPR in Burma was only 5%⁴².

(In Chile CPR increase from 5 to 25% could reduce mortality from abortion by half and decrease hospitalization for abortion complications by 29.4%³⁸.)

During 1983-87, out of 8 maternal deaths at the Workers' Hospital Rangoon, six died from abortion complications⁴³.

In the Women's and Children's Hospital, South Okkalapa, 50% of the maternal deaths during 1978-82 were from abortions (22 out of 44). During that period 22,468 deliveries and 10,623 abortion cases were treated⁴⁴.

Ba-Thike points out that in 1992 and 1994* sepsis following abortion resulted in 60% of obstetric deaths in Burma. She stresses the need for quality contraceptive services. Even if Burmese women used contraceptives high failure rates were noted^{21,45}.

Worldwide each year 8 to 30 million pregnancies⁴⁶ (or an estimated 34%⁴⁷) occur due to contraceptive failures. Women with contraceptive failures make a substantial proportion in induced abortions.

In Burma and Thailand safe abortion is illegal except for saving mother's life. In December 2005 Thailand has tightened the indications for induced abortion. Rape and incest were ruled out⁴⁸.

* in prospective studies in all specialist hospitals

HISTORICAL SUCCESSES IN THAILAND, SRI LANKA, MALAYSIA

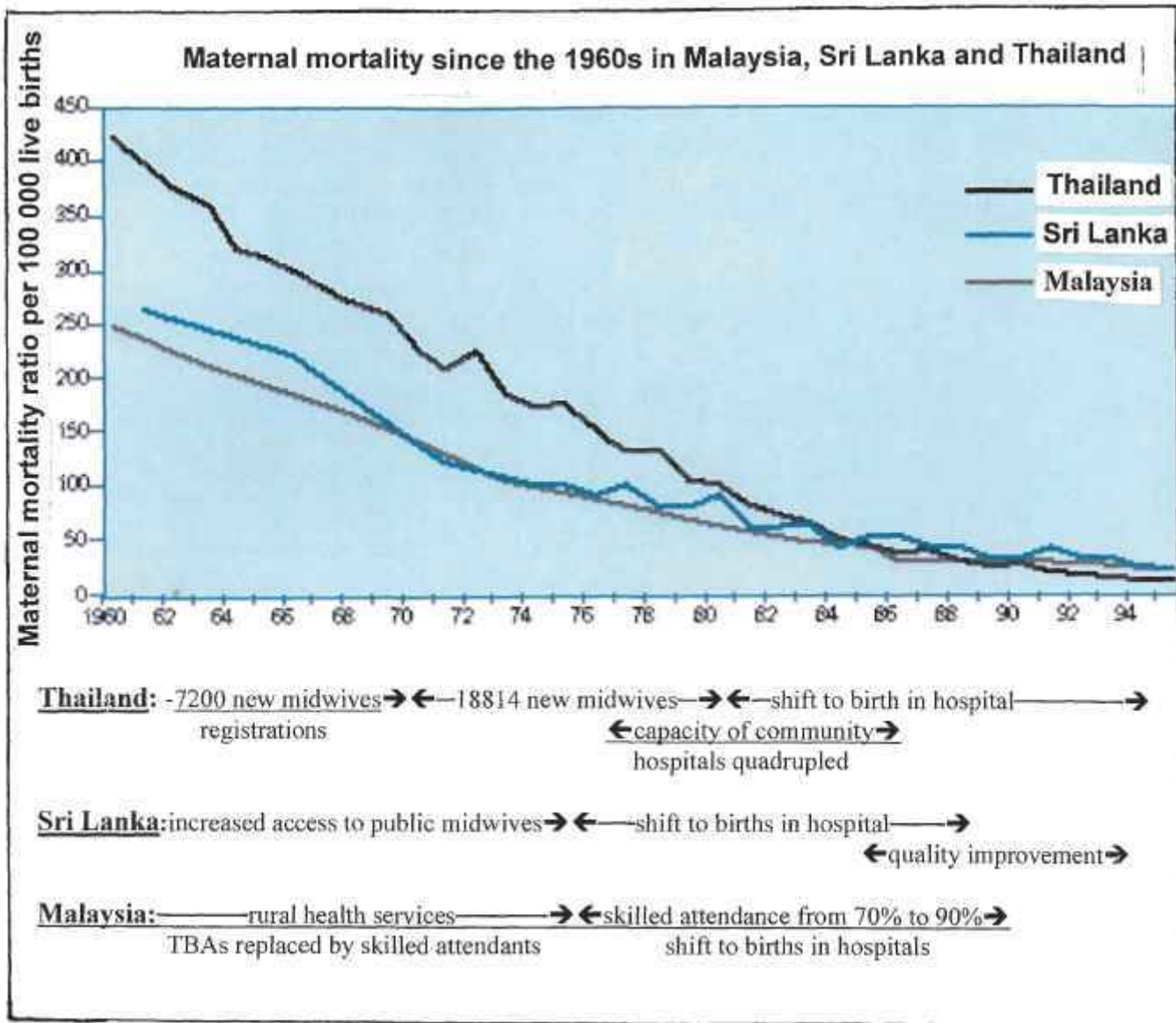
Thailand, Indonesia and Malaysia have used TMs in an integrated way in their maternal health policies including for contraceptive promotion. Training new midwives and training TMs in complementary care programmes marked a generation-long transition period towards hospital birthing. Sri Lanka with good transportation and health personnel infrastructure did not have to rely on TMs.

CPR is one of 17 core indicators of reproductive health⁴⁹. The Southeast Asian CPR in 2005 was 59%, in Thailand 79%⁵⁰. Official data for Myanmar state that 37%* of married women or women “in union” use any form of contraception⁴⁹.

Thailand’s policy for contraceptives distribution at all levels of health care started in 1970. The TFR decreased from 6.3 (1970) to 1.7 (2005)⁵¹. During the 1960s Thailand’s MMR was well above 400 and decreased within 4 decades to 40⁵². High female literacy rate, employment, improved status and economic independency of women, increased capacity of community hospitals, all contributed to reduction in MMR³⁵(see graphic next page).

Similar results can be observed in **Sri Lanka** and **Malaysia**. Since 1960 the TFR has fallen gradually in both countries in a linear relationship with the MMR decline. Decreased reliance on unsafe abortion due to improved contraceptive access also contributed to lesser maternal deaths^{53,54}.

* The official data from the Government of Myanmar (Burma) may not have included the ethnic populations in their records, because they never conducted health surveys or provided health services to IDPs. The IDP areas have been only assessed through NGOs and ethnic organizations.



www.who.int.whr/2005/

THE ROLE OF LOCAL MIDWIVES

Can training traditional midwives make a difference?

Looking into history in some Asian countries the colonial policy was to “eradicate” traditional midwives^{56,57,58}.

In the 1970s promotion of TM training was a large scale institutionalized initiative together with PHC, both major concepts from WHO. Since the shift of concepts towards skilled attendants in the 1990s the value of TM training is questioned. Recent publications follow fashionable trends and it is the money that influences the research projects⁵⁹, TMs are to be “phased out”⁶⁰.

In the Safe Motherhood Action Agenda Fortney makes the strong statement: “TBAs cannot prevent or treat most life-threatening obstetric complications, so it is a waste of resources to train them.” Further she explains that TMs have only direct impact on 2 causes of reproductive death: infection and haemorrhage³⁶.

30 years of evaluations are a good source to draw on. The effectiveness of TM training has been questioned by findings that reported maternal mortality increased after training. 80,000 more deaths than estimated before were found in 1990⁶¹. Instead of devaluing TM-training, it may be the training has brought more and clear access to the real magnitude of the problem. Among Burmese IDPs as soon as TMs were asked to document maternal deaths, fatality numbers increased¹³.

The shift in emphasis of the international funding agencies means the TM issue has recently been neglected.

In an anthropologist's review TM trainings in **Nepal** have been questioned as the information flows from biomedical obstetricians to local women, but not from TMs to cosmopolitan obstetricians. The asymmetry between ideas and practice of trainees and medical knowledge is criticized³¹. Pigg emphasizes the importance of not generalizing "traditions" but to speak about values, situations and practices in specific contexts. These socio-cultural factors are important confounders to be taken into account rather than being used to criticize TMs.

Kamal reflects that to speak of 'untrained TBAs' that need to be trained is a devaluation of indigenous midwives with often long non-formal apprenticeships⁶². Pigg suggests skipping the biomedical model of managed obstetrical care-training and introduce a dialogue about values, knowledge and concerns of the women involved. It is not about either "saving lives" or "respecting culture". These opposites are created ideologically and biomedically in Western thinking and programmes of the development paradigm⁶³.

TMs had no conflict of interest with fertility regulation, because they hardly receive any income from deliveries. They perform a meritorious role in their villages alongside other health care tasks rather than a midwifery profession⁶⁴ *.

* Statement is based on researches in Indonesia (Djuarini 1971, Poerwodhihardjo 1972) and the Philippines (del Mundo 1974).

The effectiveness of TM services is often hampered by lack of support, supervision and referral systems. TM promoters suggest not to abandon the whole concept but to improve the collaboration, equipment and facilities²⁸.

A meta-analysis by Sibley demonstrates significant increases in knowledge, attitude, behavior and advice among trained TMs. Even if referral facilities and other linked health care providers were to be upgraded, the communities, families and pregnant women need to be involved through education, awareness and motivation towards better pregnancy outcomes^{65,66}.

To enhance or replace indigenous midwives: a resource or an obstacle?

Reviewing the role of TMs, several authors state the services of trained TMs in the past three decades in more than 70 countries had very limited success. Impact on reducing maternal mortality rates can not be found because factors like lack of supervision and referral systems distort the outcome⁶². Underreporting and misclassification of maternal mortality* make this so frequently used most important sole indicator unreliable^{67,68}.

De Brouwere et al review the TBA strategy as a “dead end” and praised the training of “young and better educated women, not of recycling (sic) traditional birth attendants”. Namboze speaks of training TMs as “creating a substandard cadre which will never pass examination”⁶⁹. Lack of supervision and lack of support for the peripheral TMs have a discrediting impact on the whole TM strategy. Continuous supervision for TMs in remote areas where no

* Maternal mortality rate as indicator needs to be questioned: MMR relates only to one pregnancy a woman has at a time and not to the number of pregnancies she is having in her reproductive life time.

professional staff want to work is not sustainable. High rates of illiteracy among TMs challenge Western-style education systems designed for a literate audience.

Piper is in favor of continuing TM training programmes, using TMs as available human source, but the training should be a “two-way process”, trainers and trainees learning from each other. The success of training programmes depends on the attitude of the trainers and how the training is carried out. She summarizes in her review the need for appropriate referral back-up, adaptation to the lack of formal education, considering training costs versus TMs with only small case loads, TMs’ limited ability for life-saving interventions, and not using TM training as single approach to reduce MMR. Over-ambitious and inappropriate training programmes lead to failures. Trained TMs may adopt practices, such as regular vaginal examinations, which can result in increased infection and thus training can have detrimental effect³⁰.



Figure 6

Traditional midwife training in Mae La Po Tha, Burma

Training, trainers and supervision

Training of TMs varies in duration and content. Some curricula are overcrowded with unnecessary topics and details. Trainers vary: local health workers, midwives and doctors function as part- or fulltime trainers and supervisors. Depending on incentives trainers may not take their task seriously.

Most of the training is based on 'learning', seldom on 'unlearning' harmful practices. TM trainers are often not qualified and seldom monitored. Supervised practice in safe delivery is mostly inadequate, because the trainers do not accompany TMs during home-deliveries. Few exceptions give bedside training in health-centers and hospitals⁶².

Refresher courses are important to collect and dispel rumors. After a refresher course TMs doubled the number of recruited acceptors, but enthusiasm waned quickly after 2 months⁷⁰.

Weaknesses in previous TM-training-programmes are that trainees are taught immediately to refer complications, but how and whether this help is accessible, and where to refer are issues not discussed. That local midwives travel in their own time, spend their money and often receive "a cold welcome" from health facility personnel is another factor undermining success. Overloaded with expectations from programme managers TMs are frequently not given the promised replacement of items in the delivery kit, and reimbursement of travel costs remained empty promises.

Change of project directors caused lag in supervision and loss of morale.

Personal conflicts between midwives and TMs caused difficulties in supervision and motivation⁷⁰.

COUNTRY STUDIES

From Nigeria⁷¹ to Lao, several project reports show that TM training has reduced maternal deaths at least indirectly through birth spacing.

LAO PDR has many similarities with Burma: ethnic groups, 90% home deliveries with TMs, high MMR, high illiteracy among rural women, and Buddhist religion.

In a **Lao (I)** project simultaneously maternal and child health (MCH) centers were established and TMs were trained. District health staff cooperated closely with TMs. They provided annual refresher training and had good supervision of the TMs. The referrals increased and contraceptive uptake grew from 12% (1997) to 67% (2003). No maternal death had been reported for over five years. The high illiteracy rates did not seem to be an obstacle^{72,73}.

TFR in Lao fell from 6.3 (1990)²⁶ to 4.6 (2005)².

Lao (II): A community training approach involving lay midwives, village health volunteers and all women of reproductive age was effective in increasing contraceptive uptake within 2 years from 18.2% to 51.5%. Health education was provided to all villagers and TMs. The educational level of women was an important factor: women with schooling were more motivated to deliver with trained TMs and use contraception than women without schooling. In this case: the increased uptake of contraceptives had no effect on decreasing abortion (p-value 0.932)⁷⁴.

MALAYSIA has a well documented TM Government Family Planning Programme since 1967. 1000 TMs received a 3 week 'orientation course', including one week FP. At that time 40% of deliveries were still assisted by *kampung bidans* (TMs). 80% were illiterate, 84 % were over 40 years. A follow-up training (2½ days) for the already trained TMs was focused on contraceptive pill distribution only. Acceptors were given contraceptive pills by professional health staff and the TMs were to resupply the clients by home visits if they did not show up. This rigorous system of control was backed up by paying the TMs monthly allowances. TMs should recruit new acceptors and refer them to health clinics. A system of bonus-payment for the best performers led to duplicated recruitments. TMs had an initial active role in new recruitments, but as soon as their catchments area was finished no new acceptors turned up. Continuity rates were difficult to maintain. There were false rumors from untrained TMs versus trained incentivised TMs⁷⁵.

The TMs recruited between 11 and 31% of their postpartum mothers for contraceptives. Each Malaysian TM had an average of two new acceptors per month⁷⁶.

TMs with poor performance received warnings and continued unsatisfactorily performance led to exclusion⁷⁷. This highly regulated programme was evaluated after 7 years as successful. Key factors for success were definite

assignment of functions and tasks, organization of good operational steps and strict supervision. Costs per each new contraceptive acceptor were US\$ 9*.

Incentive programmes for TMs were effective only initially, not on a long-term basis. TMs also discouraged women to go to professional health centers because they wanted to increase their number of clients and their bonuses. Overambitious TMs even were 'stealing' patients from clinics by persuading women to discontinue contraceptives, so that TMs could report them as new recruited acceptors and get the bonus⁷⁸.

Critics state that once commercial incentives are used in a programme it is almost impossible to use educational strategy⁷⁵.

The outcome in different Malay regions shows great varieties.

TMs were considered as transitory important until they were replaced by school trained midwives. TMs were integrated in the government health care delivery system⁷⁹. TFR decreased from 6.94 (1960) to 3.26 (2000)⁸⁰.

NEPAL: Incentives were given during the training, which attracted unsuitable candidates with no interest in midwifery work. Women attended a 10 day training merely for the status that was associated with the foreign organization. In contrast, in other countries without monetary incentives good results were obtained by recruiting motivated TMs³¹.

* This figure is only for the direct project operational cost, not including costs as health facilities, health personnel, contraceptives provided by the government. It costs \$4.67 to recruit one acceptor only counting the payment to the TBA, \$5.63 with training expenses included, \$ 5.87 including bonuses and follow-up meeting. \$9.00 includes headquarters staff travel for training and supervision and petty cash operational expenses. (Peng, see endnote 75)

THE PHILIPPINES train TMs since 1956 with UNICEF assistance. In the first 18 years 9,000 TMs received training for MCH. In 1972 FP was introduced as an additional task for TMs. A feasibility study⁸¹ examined the effect of TM involvement in FP.

Supervised salaried TMs were given a target to recruit 10 new contraceptive acceptors per month and attend 5 follow-up cases. If a TM failed after 3 months she was replaced. TMs with stipends recruited three times more acceptors than those without. Supervision had an important effect: Supervised TMs obtained double the number of new clients than non-supervised TMs.

But the overall recruitment did not meet the high set target. A group of 142 stipended and supervised TMs motivated a total of 1021 acceptors in 15 months; this is less than 0.5 acceptor per month per TM. That “best” result meant only 3,6% of the eligible women started a modern contraceptive (pill or IUD).

The study concludes that transportation posed a major problem in remote areas in getting clients to the clinics. There was a problem with follow ups, because TMs lost customers to clinic-staff, who had to meet their quotas. A weak point was that TMs only motivated women who they already attended, their outreach radius did not grow.

Meanwhile the Philippines made literacy a requirement for selecting TM-trainees⁶². TFR fell from 7.13 (1960)²⁶ to 3.3 (2005)¹¹.

THAILAND: In the 1970s when Thailand still had 80% of deliveries depending on paramedical personnel, TMs were mainly trained as FP motivators not as dispensers of contraceptives. Only after referring women to health centres who started clients on contraceptive pills, TMs could give follow-up treatment⁸².

In the 1970s Thailand experienced a serious shortage of medical personnel in rural areas. Auxiliary midwives were allowed to prescribe oral contraceptives; condoms and Depo were introduced later.

A preliminary report of TM utilization in FP in four Thai pilot areas summarizes: "They have not met our high hopes for them as family planning motivators. Only half of the study group was active in the first 10 months. The number of acceptors is small; the continuation rate for pill acceptors is less than 40% at 7 months⁸³".

A study⁸⁴ on a pilot project about FP implementation through TMs gives insight into the beginnings. An initial informal 4-day-training in FP with audio-visual materials in a lively enjoyable atmosphere for selected young educated TMs was followed by two necessary refresher courses to correct misunderstandings about contraception. Simultaneously community leaders (of whom 48% were using a birth control method themselves at the time of the survey) were trained by a doctor and a nurse. Village leaders played an important role as supporters. Even in the beginning of the involvement of TMs for fertility regulation, already 75% of the TMs used to advise women on contraceptives before the survey was undertaken. Close cooperation between health workers and TMs was beneficial. The average number of acceptors TMs recruited per month was between 1.12 and 2.97.

INDONESIA's TFR decreased from 5.67 (1960) to 2.35 (2005). MMR is still high (334/100,000)²⁷. Increase of CPR did not decrease MMR.

79% of poor income women still deliver with TMs. Many of the 13,000 islands have not yet access to skilled attendants⁸⁵.

First surveys about TMs with training in FP in Central Java were interpreted as a disappointment. On average TMs recruited only two or three new acceptors per month⁸⁶. A change in strategy with mobile teams doing home visits through village health workers was not successful.

A study in Eastern Java on FP-trained TMs showed the traditional midwives were enthusiastic only in the beginning 2 months. The TMs themselves had no experience of birth spacing and did not use contraceptives. One third was worried about loss of income. A mass FP-promotion approach through various religious and civil groups made the role of TMs marginal⁸⁷.

Now the Indonesian FP-programme has village FP-posts with midwives. It was not enough to distribute contraceptives but a medical back-up system was needed to check rumors about damaging impact of birth control methods and to give clients a feeling of confidence in a setting where clients can come without shame and embarrassment⁸⁸.

One positive effect of presenting contraceptives through TMs was to limit fears and rumors attached to contraceptive methods' side-effects.

As influential women, indigenous midwives have been involved in national FP-programmes, but were seen as determined conventionalists rather than innovators. The significant correlation between the number of trained TMs in a village and the current user rates shows the importance of TMs for FP⁸⁹.

The image of the programme is an important factor; Indonesian villages involved village leaders as responsible implementers who recruited many villagers; this tactic brought wide acceptance among the population and it was not regarded as an external intervention.

In Java a special community organization 'Paguyuban KB' (FP acceptors groups) carried out an important role in publicizing and handing out contraception⁹⁰. The positive attitude of the current users (prevalence) attracted villagers who actively sought their counseling.

Periodic evaluation and a continuous sensitivity to the need for redesign are essential. Area specific adjustments and priority for individual field problems' solutions are important ingredients of success⁸⁹.

Linking fertility regulation with other educational and health programmes made acceptance easier. Key factors of Indonesia's FP-achievements are strong community participation, with over 500,000 voluntary field workers, almost 300,000 acceptor groups, and 76,000 village distribution centres. Indonesia has trained 5,000 to 7,000 midwives per year which are sent to the villages⁹¹.

GUATEMALA: In most evaluations on the outcome of TM training nothing is mentioned, about how TMs were recruited for training. Did TMs request more knowledge and support or were they ordered from health institutions to participate in training? This might be an important motivation factor.

A midwifery model for training in Guatemala⁹² stands out from most TM projects. Training philosophy and intensity, curriculum content, continuing education of the trained TMs and follow-up supply support were essential pillars for success. Initiated by a certified nurse-midwife, the approach of Midwives for Midwives (MFM) is a unique egalitarian concept far from the usual top down hierarchic implementation. Information was shared horizontally. TM's self-esteem and perception as community health promoters were crucial. TMs came up with the need to discuss details of their experiences. More and more TMs requested to be trained. In this programme TMs were respected as bridge between community and emergency services, as educators, facilitators and agents of change. They mobilize resources for the well-being of the families. The exchange of understanding medical obstetric and indigenous practices was adapted to the scheduling needs of the TMs in a 150 hour course with biweekly follow up support meetings. Collegial relationship with professional midwives was a key in this project. A problem was functional literacy: TMs were unable to keep records of their deliveries, not even with symbol charts. Introduction of referral charts from TM to physicians was overambitious and unrealistic.

PROBLEMS TO FACE IN NON-REFUGEE SETTING

Culture, laws, religions and community perception

Foreign involvement in programme funding, design and implementation can create perceptions that fertility regulation violates national culture. Anything 'alien' can be perceived as threatening.

Religious leaders in Indonesia first held back the programme by tacit or open opposition. Only after many conferences and seminars did some religious leaders become contraceptive promoters.

In Malacca TMs received 1 year of midwifery training in the hospital despite their low educational status. Even with more training the outcome of fertility regulation among less educated women did not improve. Misconceptions lead to failure rates. During the Muslim fasting month Ramadan or during absence of the husband women discontinued contraceptive pills. Many pregnancies occurred after Ramadan⁷⁸.

Even if clients are using contraceptives the continuation is dependant on the perception of risk and fears. Actual side-effects and peoples' beliefs, rumors and fears can be different. Misconception, lack of knowledge about anatomy from the community can lead to abstruse conclusions and exaggerate fears that lead to discontinuation.

It is not enough if a client accepts contraceptives from an implementer. Often the surrounding community is consulted; if friends, neighbors, religious leaders, village heads, and TMs all have a favorable acceptance towards a contraceptive method, the client will continue⁸⁸.

Governments did not allow fertility limitation in Burma, Mongolia, DPR Korea⁸⁸.

Maternal health depends on the educational level of women

A study in northern **Lao (III)** on the impact of TMs on reproductive health found that the educational level of women was an important factor: literate women practiced more child spacing. The improvement of maternal health depends not solely on trained TMs but on their clients' ability to read⁹³.

A survey in Thailand found that underutilization of MCH services were the effect of maternal education. In areas with low female literacy, small increments in education have a substantial impact; but a distinct positive effect emerges only after secondary schooling. Other variables like religion and rural residence affected the use of health services: Buddhists and urban residential were more likely to attend prenatal care and plan their births than Muslim and rural women⁹⁴.

Table 3 Female illiteracy is an important factor contributing to MMR

	MMR⁹⁵	FEMALE ILLITERACY, ADULT (PERCENT)²⁶	
	1996/2000	1980	2003
Thailand	44	17.4	5.4
Sri Lanka	92	20.6	10.1
Malaysia	41	37.7	14.4
Indonesia	230	40.6	15.9
Myanmar (Burma)	360	34.2	18.1
Cambodia	450	60.9	39.8
Lao PDR	650	67.6	43.4

Thailand's female illiteracy rate decreased from 17.4 (1980) to 5.4 (2003). Indonesia had a more difficult start with over 40% non-literate women in 1980 and has now reached the level Thailand and Sri Lanka began with 25 years ago to improve schooling for girls; the latter are one generation ahead of Indonesia.

As literacy rates rise, illiterate TMs will naturally disappear.

Old aged TMs, unmotivated health staff

Age of Thai TMs as important criterion: 77% were between 50 and 70 years, did not want to work, tired easily and had problems to walk far. The under-50 group was more active in recruiting contraceptive users⁷⁰.

An examination of Philippine TMs' delivery kits uncovered that majority of kits had not been used or used very little⁶².

False rumors caused loss of continued users: fear of darkening of skin, of getting pregnant despite pill, weight gain was among the motives to discontinue. A pill brand change caused decrease in 20% of all acceptors.

A midwifery centre could not provide IUDs, and women were disappointed when they went there and the clinic was closed, because the midwife was on home visits.

Some new health workers lacked mercy and sympathy and motivation to work with poor and ignorant villagers.

Racial and communal divisions

In countries with interethnic tension and conflict issues like Sri Lanka, Malaysia, and India, perception that survival of an ethnic minority depends on increased population to outdo the enemy can block contraceptive uptake. Fertility programmes can be suspected to support opponent groups.

Ethnic minorities might not understand the language of the implementers "nor is it likely that someone will talk about so sensitive a topic as contraception with someone outside one's ethnic group"⁸⁶.

Care drain through globalization

Skilled birth attendants, nurses, doctors are leaving resource poor countries. The migration is seriously affecting their health systems. Western countries cut down on their own training programmes for midwifery schools and Gyn/Obstetricians^{96,97,98}.

The WHO/UNFPA/UNICEF statement to ensure a skilled birth attendant for all⁹⁹ might be not realizable in the near future.



Figure 7

Forced Migration

Maung Maung Tin

REFUGEE SETTING

In 1994 it was Women's Commission for Refugee Women and Children's milestone report¹⁰⁰ that the much neglected issue of Refugee Reproductive Health was recognized in Cairo on the ICPD*.

Searching literature for 'reproductive health' and 'refugees' all publications were found after 1993. Surveys on scattered IDPs still need to be done, refugee camps are easier to be accessed. Most authors express the need of further research RH among IDPs.

RH services for refugees require special consideration. Internally displaced people are refugees, but not having crossed a national border, they are not under the protection of the UNHCR. NGOs experience difficulties to access IDP areas, and health logistics are more difficult to implement than in refugee camps. IDPs live in even more precarious emergency situations without qualification for international protection. Violence and insecurity overshadow attempts to implement health care¹⁰¹.

Conflict and displacement situations -with failures of law and order- often lead to increased sexual violence against refugee women. Rape, sexual abuse, forced prostitution and physical assault through men are more widespread than in peaceful stable settled societies. Loss of family members, breaking down of neighborhoods, and destruction of property leave women vulnerably exposed with no bargaining power in unknown unsafe settings.

*"Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming with universally recognized international human rights." [International Conference on Population and Development. Programme of Action, New York:UN,1994].

Women with minor children feel handicapped when they need to flee, they can not carry much property if they are burdened with pregnancy or breastfeeding babies. Adolescent girls are endangered through abduction for sexual assaults by army and police.

The RH inter-agency Field Manual for refugee situations includes in addition to safe motherhood, chapters on MISP (Minimum Initial Service Package), sexual violence, FP, sexually transmitted diseases, post-abortion care and other RH concerns¹⁰².

Emergency contraception (EC)

In prevention and management of gender-based violence the provision of emergency post-coital contraception is vital. Availability of free condoms must be guaranteed. In forced population movements sufficient condom supplies should be distributed with making potential users aware were to obtain them. EC is a worldwide largely under-used method, except in some Western European countries and China¹⁰³.

Médecins sans Frontières (MSF) states there should be a demand for fertility regulation services in the refugee population, this demand should be thoroughly assessed, and the continuity should be guaranteed for at least 6 months¹⁰¹.

A survey from the International Rescue Committee (IRC) found that only 4 out of 14 settings had EC available after it was introduced into their programmes. A case study from Tanzania found, that still more education, and information about this method was needed in the refugee communities, more staff training to extend better access for EC was necessary¹⁰⁴.

“Many NGOs see it [RH for refugees] as a luxury and not an emergency” states Guest from Mahidol University, Bangkok, NGOs give priority to malaria treatment not birth control among the Burmese refugees. He states, in Burmese refugee camps only 8% had access to contraception and only 32% knew about fertility regulation¹⁰⁵.

Birth rates in refugee camps are typically higher than in the host-country population. Sex relieves the boredom of camp life; people want to replace lost children, recently widowed need companionship; new friends become sex partners. RH services for refugees have often been reduced to limited care for pregnant women¹⁰⁶.

Krause et al emphasize the importance of multi-year funding for refugee RH services. Follow-up staff training, supervision and the continuity in supplies are essential to stabilize those who live in unstable conditions. Thus the humanitarian relief intervention grows into sustaining development¹⁰⁷. From the beginning relief organizations should provide refugees’ demand for contraception¹⁰⁸.

- ◆ Have TMs been trained for contraception promotion in displacement settings?

THAILAND: A study in a **Karen refugee camp**¹⁰⁹ explored the under-utilization of a hospital for delivery. Karen women preferred to birth at home with TMs despite the short distance to the camp hospital. Only 30% of antenatal care clients delivered in the hospital. Out of the 89 mothers

participating in the exploration 66 said shame (*“anadeh”*) was the reason. In the hospitals their legs were not covered fully with a sarong, vaginal examinations and presence of male health staff made them feel uneasy, also they preferred to stay with family and friends and the close relationship with the TM was a factor for traditional delivery.

Nothing is written on contraception.

CAMBODIA: A study¹¹⁰ in **Khao Phlu refugee camp** with 12,000 Khmer refugees found that none of 130 interviewed women in reproductive age and married men were familiar with EC. Only 2 of 10 asked midwives and none among 21 asked TMs knew about the method.

36% of the interviewed women had no formal schooling. 30% knew of women who had been forced into trading sex. Morrison describes a difference in perception of rape: in Western understanding rape is a situation where a woman is forced to have intercourse. Cambodians perceive intercourse as something a married or widowed woman cannot refuse. Domestic violence in Cambodia is high. A man can extort sex for food, protection or money from a widow. Secrecy and shame surround rape and therefore is rarely reported. 8% of women of reproductive age were not accompanied by men and lived in female-headed households, they were believed to be confronted with unwanted sexual advances for “protection”.

82% of married women did not want pregnancy, but only 12% interviewees used modern contraception. Reasons for non-use were fear of

side-effects (61%) and discomfort over seeking contraceptives (42%). After education about EC, traditional midwives had “difficulty understanding the specifics of using the method”. 6 months after extensive staff training CPR was only about 10%, almost no woman had received EC.

Morrison recommends it is stressed that women can use EC for any unplanned intercourse. Assessment for EC should be done by examining frequency of unplanned intercourse, not by asking how many women have been victims of rape. Health Care was provided by American Refugee Committee/UNHCR. 10 midwives distributed contraceptives, 41 TMs attended home deliveries.

Problems were:

- Fluctuation of midwives: young (4 were <17 years!) inexperienced midwives were trained to replace older experienced ones who repatriated.
- Negative attitude of midwives: not to give contraceptives if women are unmarried, younger than 18, older than 42, childless, if they had recently given birth or had an abortion, or if they were commercial sex workers or unhealthy. 13% (10 women) of the interviewed women asked the midwives for contraception and were denied for above reasons!
- Lack of information: women did not know that contraceptives were available at the health centre.
- Misperceptions about modern contraceptives: side-effects of traditional contraceptive herbs as weight loss and fever were reassigned on modern contraceptives.

ETHICS

Informed consent is considered a human right and is absolutely essential in fertility regulation programmes. Policy makers have responsibility as protectors of those with diminished autonomy. In the past, Nazi-regime, India and China violated human rights through forced sterilization. Information overload or incentives to illiterate, impoverished people affect the consent. If already traumatized refugees depend on others for food and materials for survival they might consent to anything that is suggested¹¹¹.

Critical NGOs* removed their names from the UNHCR Field Manual. They accuse UNHCR for their "cavalier attitude towards contraceptive safety" and believe the manual being "intentionally hijacked by US population interests". "Captive populations" should not "become a vehicle for population control"¹¹².



MaeLaPoTha-5000 displaced people settlement

Figure 8

* OXFAM and Save the Children

DISCUSSION

▣ TM CAPACITY BUILDING

Previous criticism of TMs has often relied upon research with methodological limitations such as a discrepancy between TM training curricula and the expected health outcomes.* The skills taught to them did not have direct influence upon mortality, but TMs were evaluated for their ability to reduce mortality. Only when the trainings were focused on a particular subject i.e. contraceptive promotion, and the monitored outcome was the same subject, there was an evidence of a result directly related to what was taught.

It is too simplistic to conclude that if the majority of births worldwide are attended by traditional midwives and the maternal mortality is high, that the fault is with those with best intention hard working indigenous midwives. A conglomerate of factors leading to maternal deaths has been acknowledged by WHO. Instead of eradicating illiterate TMs, there should be eradication of illiteracy. Instead of eradication of maternal deaths there should be eradication of causes that are leading to maternal deaths.

The dual role of TMs in birth attendance AND birth control needs more investigation. Birth and birth control are two sides of the same coin. Belton and Maung have pioneered this field^{22,113}.

It is disempowerment if TMs are only trained as contraceptive promoters and need to refer the recruited clients to professional health staff. Only in Malaysia TMs were allowed to resupply monthly pills. Nationwide TMs are allowed to deliver babies, a much more dangerous medical procedure and they

* Dr Tom Lee. Building Capacity for Delivery and assessment of Adapted Maternal Health Interventions for Internally Displaced Persons in Burma. GHAP Proposal, 2004.

are performing unsafe abortions. To empower TMs means to enable them directly to decide and distribute freely modern contraceptives.

It would be interesting to research whether Chinese community-oriented paraprofessional barefoot doctors, combining traditional and modern contraceptives, can serve as a model approach for the Backpack-Teams and TMs in Eastern Burma.

▣ CHANGING POLICIES

Family Planning is out: Does Fertility Regulation come in again?

The reduction of funds for contraceptives due to rising political conservatism in the United States has eroded sexual and reproductive health services¹¹⁴. HIV/AIDS is the winning competing issue, drawing attention away from contraception. As long as the unfinished agenda of unmet contraceptive need, unwanted fertility and shortage of contraceptive supplies is prevailing, the benefits of fertility regulation for reducing abortion and reducing poverty should be highlighted¹¹⁵.

Even if there were enough skilled birth attendants, no transportation problems and full access to BEmOC*, this could not completely prevent the high number of unsafe abortions and the deaths from abortion complications. Additionally a clear programme for fertility regulation needs to be implemented, especially in a country with a 'culture' of induced abortion like Burma.

* Basic Emergency Obstetric Care

▣ LEARNING FROM OTHER COUNTRIES AND FROM HISTORY

The **Malaysian** TM programme demonstrates that an FP-programme alone is not effective; the multifunctional role of lay midwives in MCH is a natural entry point for fertility regulation. A single short time of training in Malaysia was not enough. Continuous refresher courses need to be offered. Longer TM hospital training with predominantly ethnic Chinese doctors did not bring a better result, because the rural ethnic Malay population was not educated. Illiteracy has an important impact as a risk factor.

A well organized programme like Malaysia had only modest results: 2 new recruited acceptors per month per TM is that worth the effort for training? Capitalistic incentives can be contra productive: it can create jealousies among untrained TMs or can tempt TMs, not to refer clients to health centers, but to save the patients for their own profit. Dropout TMs who could not perform well turned against the fertility regulation programme and spread false rumors. Until 1985 Malaysia received a lot of international praise and was frequently referred to as a model. But the centralistic approach of Malaysia bears a taste of Indian coercive FP programmes. In none of Peng's publications comes in an understanding for the Malay cultural reservations¹¹⁶.

In 2005 Thailand had a stable low TFR (1.7) whereas Malaysia still had 2.8². Conclusion: Short-term evaluations do not suffice how many the publications may be; decades of history depict a more accurate evaluation.

The well documented Malaysian programme gives a good basis for analyzing interactions. The multitude of impact factors for TMs such as mode of recruitment, length of training, refresher course, supervision, cooperation,

incentives can not be underestimated and make a linear outcome expectation impossible. Another important factor is religion or cultural habits and beliefs.

The integrated approach in the two **Lao** programmes (I, II) with information campaigns in the villages addressing women plus health volunteers plus TMs and frequent supervision was an essential component for success. But the northern Lao (III) project shows that two weeks TM training without supervision and refresher training does not have any impact on contraceptive uptake.

The **Guatemaltecan** midwives for midwives model provides inspiring ideas for soft skills and details about trainings. The clinical outcome, the benefit for the clients still awaits evaluation.

I was looking in vain in all the studies how often the TMs were integrated in the birthing process after they have referred a woman*. The Guatemala midwife project was the exception. Thai and Myanmar hospitals, even the above Karen refugee camp hospital did not allow accompanying TMs into the delivery wards, thus creating a gap rather than a bridge of power/knowledge¹¹⁷. This can be a contributing factor to the failure of some TM-programmes. Building collegial friendships can be a good base for knowledge transfer including contraceptive promotion.

* Illiterate TMs found it very useful when they accompanied a woman to the Mae Tao Clinic and accompanied the delivery with a midwife. The relationship and the learning effect in such practical case studies proved to be very appreciated by TMs.

A successful country like **Thailand** shows, that even where all circumstances were favorable (previous knowledge of TMs about contraceptives and village leaders being involved with follow-up refresher motivation-trainings), TMs will have on average 2 new acceptors per month; this confirms the experience in Malaysia and Indonesia. Overexpecting programme evaluators interpreted these results as negative, but seen over decades it needs to be understood as a realistic positive result. One should not expect dramatic growth rates on contraceptive uptakes. Thailand's CPR decreased slowly but steadily. Details of such studies reveal the enormous effort and intensive staff involvement. Careful planning and continuity of a programme interlinking all available social structures committed to a common objective are necessary.

Thailand avoided creating enemies from dropout TMs as in Malaysia. Through a level-system of different upgraded skills and responsibilities the best use was made of all TMs, some as simple information promoters and some as skilled counselors in side-effects. Involving doctors, midwives, nurses, village headmen and experienced TMs as trainers a broad support system was established. Increasing literacy among younger TMs allowed to use them as a "change" agent and convert them from a motivator to a functional FP worker.

In **Indonesia** decreased TFR did not necessarily decrease MMR. A multitude of other factors like educational and gender status, poverty, and lack of transportation aggravate to maternal deaths¹¹⁸.

A solution can not be found in a linear mono-causalistic way, but in a broad complex approach from all possible resources including the TMs. When TMs received FP-training and started to work, their enthusiasm waned quickly.

Once acceptors groups were established contraceptive programmes seem to run by themselves. New satisfied acceptors were the best promoters.

The more lateral support came from other linked programmes the better the outcome.

TMs can serve as liaison between communities and health centres.

Because of their accessibility and availability TMs can sustain motivation for contraceptive use.

▣ THE 'ANADEH'*(SHYNESS) FACTOR

Cambodian refugee camp Religious, cultural and even language-similarity of Cambodian Khmer and Burmese Mon population¹¹⁹ allow the assumption that rape in and outside marriage among Burmese IDPs is underreported. TMs might have difficulties to assess the problem, but can be encouraged to ask about “unplanned intercourse”. Education on EC is vital.

Though the sample size of the study was small, insights into obstacles for delivering contraceptive services can be obtained. Concerted efforts are needed to dispel misconceptions and to overcome embarrassment (shyness).

Karen refugee camp Even if modern facilities were available, the Karen did not use it as expected. Main factor is embarrassment. The same shyness (“*anadeh*”) is a dominant factor in not using modern contraception.

* ‘Anadeh’ is a frequently used Burmese word for what is culturally not acceptable. It is used as embarrassed, shy, discomfort, impolite, inappropriate. It is the most frequent used word to avoid conflict, confrontation, criticism and to behave in a harmonious smooth way. In the Burmese value system rule number 1 is ‘no anadeh’.

How to offer contraceptive choices counseling for multi-traumatized women who had no previous contraceptive history will be a challenging task for all involved.

▣ CONVERSION TOWARDS 'MODERN' OR DIALOGUE?

It needs to be pointed out that all the projects so far have been evaluated within a clear knowledge/power relation from modern towards traditional or indigenous practices. How has it come about, that local healers or local recipients of aid programmes are not asked to evaluate the programmes from their point of view? Available cultural sensitive analysis comes from Western anthropologists, feminists and human right promoters who position themselves as spokes(wo)men for, rather than biomedical reformers or live saving benefactors of TMs. There is not yet an evaluation how TMs understand success and failure. What do they regard as their key values and objectives? What do they need?

How do TMs evaluate the programme viewed from their cultural background? Such surveys still need to be undertaken to adapt the programmes and make them more user-friendly.

▣ ABORTION RELATED DEATHS UNDERREPORTED?

The discrepancy between the WHO-figures (13% maternal deaths abortion related) and the available data from Burma (50-60%) allow two conclusions: either WHO-data are underreported or the problem in Burma is country-specific, this requires further investigation. Immediate solution-oriented programmes need to be implemented and monitored.

- **OUTLOOK:** In resource poor countries TMs are cheap available health personnel.

The concept of donation of labor for the community as *SHRAMADANA* (India, Sri Lanka), *GOTONG ROYONG* (Indonesia), *DANA* (Buddhist countries) is still functioning with volunteer work performed by TMs. For interim services until enough educated health staff is available/affordable they are a useful resource. All above countries have made the best use during their transition period from TM to skilled midwives.

TMs have an important role in hard-to-reach areas and with shortage in health professionals.

Whether TMs should be utilized first in MCH and then in FP or vice versa depended on the availability of obstetric services. The main occupation of TMs could be shifted gradually from birth towards birth control, as soon as safer delivery opportunities were available in health centers and hospitals. Indonesia still has a massive shortage of midwives and relies on TMs and volunteer health workers.

- **FEMALE LITERACY**

If illiterate TMs with no own experience of modern contraception will hand out contraceptives to illiterate women, failure rates have to be expected.

The Burmese IDPs with their shortage of trained medical personnel have no other resources than to rely on TMs.

Although most TMs are non-literate, they have an influential role within their communities and communicate well, probably more convincingly than professional health staff from outside.

▣ STRENGTHENING CIVIL SOCIETY IN EMERGENCY SITUATION

Fertility regulation programmes with IDPs and in post-emergency settings are not much described. Are there no experiences, is there no money for research, or are researches too difficult under such unsafe difficult circumstances?

The double issue of TMs promoting contraception and providing unsafe abortion is not discussed together in the literature found. Why is there so little written about unwanted pregnancies and induced abortions?

In none of the research papers I found whether TMs were handing out emergency contraceptive pills.

Burmese IDPs live in an emergency or fragile post-emergency phase. Any capacity building and strengthening their own structures like TMs and mobile medical teams is a step from relief to development. No quick results are to be expected in a conglomerate of unfavorable circumstances. But with continuous sustained support, commitment and long-term planning a chance and choice for improvement is offered. Why should only couple in peaceful settings have access to fertility management?

It is strengthening the civil society and peace work by offering such services of hu(w)man rights*¹²⁰.

* “The aim of family planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available **a full range of safe and effective methods**. ... The principle of informed, free choice is essential to the long-term success of family planning programmes.”[emphasis added]

■ INFORMED CONSENT: NON HARMING

Incentives to increase the number of contraceptive acceptors among displaced people are ethically questionable.

Cost free contraceptives, free access for all (regardless of sex, age and marital status), continuous supplies, and always available adapted understandable information are criteria of respecting human rights.

In peer reviewed studies it is praised that quick achievement of 50% CPR could be done in the 1980s among Khmer refugees in Thailand. In 1993 at the Khmer Khao I Dong refugee camp there were a total of 43 NGOs competing for success. Women had received a chicken for having a Depo provera injection. But when there was a second refugee period 1997-99 only an estimated 10% CPR could be reached¹¹⁰. The first "success" was based on husbands' appetite for chicken, who sent their wives for second and third doses of Depo after 1 month to another provider and perhaps not based on consent from women themselves¹²¹.

The second programme's difficulties shows, that even when a population had a high CPR if they are repatriated they choose to discontinue and in a second refugee situation they are highly suspicious and sensibilized about the side-effects.

IMPLICATIONS FOR POLICY AND IMPLEMENTATION

It is not easy to initiate and maintain a fertility regulation programme. It is not as simple as to buy some contraceptives and have them distributed.

I had suspicion that it will be difficult and slight doubts about successful implementation. I started this project enthusiastically. But optimism can be lack of information.

Long term goals

- Peace, political stability.
- Gradual education and health infrastructure building.
- Encourage and sponsor foundations of schools.
- Emphasize importance of girls schooling.
- Increase number of girls with secondary schooling.
- Recruitment of literate midwives, improve access to referral services.
- Be realistic: Keep expectation low.
- Allow enough time,-decades- to see improvements.



Figure 9 Ethnic Karen mothers at Ma La Po Tha IDP settlement

Training & education

- Lobby for midwifery schools in developed countries (prevent care drain).
- Coordinate all TM trainings with standard training curriculum.
- Supervision of TMs through the new planned 6 maternal health centres and the newly trained maternal health workers.
- Increase number of self-selected TMs to receive training.
- Encourage trained TMs to motivate untrained TMs to attend trainings.
- Extend trainings in “birth- or child-spacing”* (this is the local present politically correct term) and emergency contraception.
- Contraceptive refresher course for supervisors: TM trainers, BPHWT, BEmOC staff (emphasis on contraceptive benefits and how to dispel widespread exaggerated fears of side-effects).
- Information, education, communication (IEC):
 - Burmese manual for fertility regulation,
 - develop new flyers on each method in each language,
 - photocopy & distribute available materials,
 - collect, adapt, translate other organisations’ available IECs,
 - distribute available secondary reading books on SRH in Burmese language to staff, textile factories, and schools.
- Use of bio teaching aids: invite satisfied FP users to talk about their experience to overcome ‘*anadehism*’ (shyness).

* “...we never say or hear **words**, we say and hear what is true or false, good or bad, important or unimportant, pleasant or unpleasant, and so on. Words are always filled with content and meaning drawn from behaviour or ideology. That is the way we understand words, and we can respond only to words that engage us behaviourally or ideologically.” [Volosinov VN. *Marxism and the Philosophy of Language*. Cambridge: Harvard University Press:70.]

Availability of contraception

- Promote first child delay and child limiting.
- Discourage teenage marriage with immediate following pregnancy.
- Lobby with “KNU” (Karen politicians) for implementation of minimum age of marriage.
- Promote married teenagers to use contraceptive pills.
- Dispel ‘sin’ concept among Christian Karen leaders.
(TM regarded sterilisation as “a kind of sin. It closes the door for babies and forbids the baby to come to earth”¹²².)
- Inform TMs about legal situation (translation of Thai § 301-306).
- Discourage unsafe abortion practices (pummeling, ‘massage’, uterus twisting, fetus-‘melting’ with hot stone, kapok-stick-, papaya-leave-stem-, and umbrella-spike-insertion), distribute contraceptives instead.
- Get TM support for FP that they don’t boycott the programme (attitude).
- Involve them actively
 - as distributors: condoms, EC (→counselling skills),
 - as recruiters for referring new acceptors for COC, DEPO, sterilisation,
 - as counsellors for follow-up motivation.
- Free condom distribution to prevent prevalence of 10% STI from further spreading.
- Inform TMs about sterilisation tourism to Thailand, ask their assistance to arrange this for couples*.
- Restocking TM kits with condoms, EC and HCG**-urine-tests.
- Identify and discuss common misconceptions such as not to use contraceptives before the first baby is born.
- Increase outreach programmes in textile factories.

*In Burma female sterilisation requires a 3 months to 2 years application time, and is forbidden for males.

** Human Chorionic Gonadotrophin

Advocacy

The GHAP project for 'Capacity Building for the Delivery and Assessment of Adapted Maternal Health Interventions for Internally Displaced Persons' is a hopeful fundament. Only with joint efforts and support from longtime strongly committed individuals like Dr. Tom Lee (GHAP) and Dr. Sandra Krause from Women Commission for Refugee Women and Children (WCRWC) and the integrity of fully devoted Burmese refugees under guidance from Dr Cynthia Maung can such a difficult task be undertaken.

- Networking with NGOs and Thai Hospital.
- Improve relationship with Myanmar Hospital staff.
- Working together with the newly trained EmOC medics and the planned MCH Centres as primary referral centres for TMs.
- Maternal Death Audit: Investigation and analysis of each maternal death with TM, supervisor, BPHWT, EmOC-staff in "non blame" approach.
- Strengthen link between health workers and TMs through meetings.
- Close the gap between skilled attendant and TM, gradually promote individual TMs with literacy.
- Gradual upgrading skills of BEmOc medics (to full method mix of contraceptives).
- Encourage TMs to organize themselves.*
- Continuous monitoring and evaluation. (TM questionnaire: age, education, number of attended deliveries, number of women who asked for inducing abortions in 2006 (NOT number of induced abortions!))

* If they feel the programme comes from another organization outside they might not identify. Grassroot level democracy: what are their needs and expectations?

Financial support (to be discussed)

- Incentives for trained TMs as a means of appreciation of their services; professionalisation.
- Fundraising for small emergency budget to be left with each registered TM to pay for fuel for emergency transportation, hospital admission or blood transfusion.
- “Travel money” paid to the TM when she accompanies a woman which she refers for delivery or Tubal ligation (increasing the referral rates).
- Village-based community bank for emergency referrals.
- For maintenance of contraceptive supplies donors and NGOs with European funding need to be contacted to replace the loss of funds. (Many NGOs with previous USAID funding can not continue their fertility regulation programmes.)
- Salaries for local skilled attendants & trained midwives (for retention in their countries).

Despite political perspectivelessness not only humanitarian assistance is needed. A long-term development of capacities of communities towards self-reliant local action is needed. Internally forced migrants have not the inertia of refugee camp dwellers. This potential can be supported.

Learning from other countries my enthusiasm is dampened, skeptical doubts arise:

- TMs might not be very efficient in this task, if they have no contraceptive use experience in their own biographies and should teach something they might not be convinced.

- Mobile volunteer health workers risking their lives in landmined war zones are not to be blamed if rural illiterate women have failures with contraception or do not accept it at all.
- Is it justifiable to send health workers in unstable areas to save lives? (In the past years several staff died from violence.)

As additional strategy is to be considered:

- Ten thousands of Burmese young migrant workers in the Thai border garment and knitting factories live closely imprisoned in factory compounds. Some had induced abortions, and some are using contraceptives.
- Factory girls are highly respected in their remote communities for cash and new ideas.
- Can young women with contraceptive and/or abortion experience be contraceptive promoters in their villages?
- Can they be agents of change and technology transfer if instructed as community-based distributors?
- Could they be leading peers in their villages, fresh wind as an additional back up for illiterate elderly TMs?

The only way to prevent one's analysis from simply becoming another naming of the problem and the platform for a new solution, is through social activism, not discursive critique³¹.



Figure 10 Karen TM had not seen condoms before the training

ACKNOWLEDGEMENT

My thanks go to Heinz for continuous support,
to DIFAEM for the interest free loan to pay the postgraduate RH course,
to Dr Cynthia Maung and my Burmese midwife- & medic friends, who
even risk their lives as mobile medical teams in landmined civil war area,
to all networking friends for the well-being of Burmese forced migrants,
to Dr Suzanne Belton for inspiration and sharing commitment,
to my tutor Dr Nynke van den Broek,
to Dr Joanna Arnold for proofreading
to the LSTM librarians Austin, Martin and Cathy.
Thanks to my teacher and webmastress Karoline Stuermer,
microplanning this thesis could be published www.mitwelt-netzwerk.de.

*“The art is seeing what is questionable”**

** There is also art in knowing how to question in a manner that makes new understanding possible.*

Hans-Georg Gadamer: Truth & Method, N.York,1975:118.



Figure 11 Health worker attends home delivery



Referral distance : a one day journey

Figure 12

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APPENDIX

In the jungle of views, concepts and agendas

What is at stake your health or my agenda? (Words 805)

It was in Bihar, India, 1983. I witnessed the Family Planning Programmes during the second reigning period of Indira Gandhi.

At that time the controversial sterilisation programmes were still going on.

The media were still full with terms like population bomb¹.

Unlike the coerced vasectomy programmes through her son Sanjiv a few years before², now there was an emphasis on Tubal Ligation (TL) which was promoted by free distribution of a sack of rice for each recruit.

Sterilisation was performed in mobile bus operation theatres with people squatting and standing outside under a tree waiting for recruitment interview³ (Bodh Gaya, 1983). The counselling was done in large groups with many onlookers. There was a rushing and yelling atmosphere pushing the willing clients in and out the operation bus as on the overcrowded ticket counters at an Indian railway station.

The husbands carried away the sack of rice on their heads while the freshly tubal ligated wives were squatting with consoling female relatives waiting for a cycle rickshaw.

A different approach was the Natural Family Planning campaigns through the Catholics. Near Patna I had the opportunity learning from the old Jesuit Father Gallagher and his female health worker staff how to explain the Mucus Method.

How could a celibate septuagenarian priest know about fertile cervical mucus?

Equipped with two bowls, raw eggs, rice flour, pencils and paper his "sisters" carried out his programme, made home visits and asked illiterate women about their menstruation cycles, drawing circles and demonstrating the white of an egg versus the sticky wetted rice flour.

It was in conformity with the Vatican not to use condoms⁴. Not to use *HIMSA* (Sanskrit for coercion)⁵, neither mental through coercion nor physical through invasive operation. *AHIMSA* (Sanskrit for non violence)⁶ was that mild priest's approach: non violence through non forcing.

It seemed to me almost impossible to explain the menstrual cycle to illiterate women who could not read even a calendar and could not count their days of menstrual cycle. With Sister Paulette from the Mother Theresa's order these Catholics tried to identify only the fertile period and preached abstinence during one week. "If wet wait" was their simplified approach.

I wondered about the efficiency. As a midwife I knew that lactating mothers had no ovulation and no slippery mucus. Despite the failure of their teaching, which was obvious from non spaced children and many pregnant women the "sisters" were always welcomed as social workers, they had time and assisted with many advices to those outcast impoverished mothers, who prefer to call themselves *DALITS* (Sanskrit for the broken, scattered, torn). The kindness of these Catholics towards those illiterate people, their softness and patience in explaining allowable Vatican methods of Natural Family Planning was in stark contrast

towards the rude rushing, pushing and yelling commanding of the Medical Team in their operation bus.

These two approaches left a deep impression on me and I vowed myself to neither deny free choice of contraceptives nor using any force.

The combination of the gentle and patient perseverance of the Indian Catholics and the offering of informed choices for modern contraceptives was my receipt to start a family planning programme later with Burmese refugees.

Since the International Conference on Population and Development 1994 in Cairo it is no longer politically correct to talk of population explosion, instead one talks of demographic bonus⁷ and population stabilization⁸.

For me the term 'family planning' is unsatisfactory. As a privileged woman from a liberal country with Western education I have chosen to be child free and family free. I understand the use of contraception not merely as a component of the reproductive phase rather as an integral part of a general life-planning. As it is stated in the WHO definition of Reproductive Health it has a biographical life shaping dimension⁹: "At all stages of life" was the full text of the Global Policy Committee of the WHO's Position Paper¹⁰.

Family planning is life planning or "life-shaping"¹¹, liberation from the reproductive urge of nature¹².

To give women access to contraception means for me to share with my sisters globally the freedom to shape their own lives not only their families, contraceptives seen as a gift for the individual well-being¹³, not only to space children or reduce maternal mortality and fertility rate.

Having come up with my own clear agenda for women's well-being I was confronted with new thickets of views when I started to work with Burmese refugees and internally displaced persons (IDP) along the Burma-Thai-border in 1990. For over 15 years I have been accompanying, training, supporting and supervising midwives in this area as a volunteer every winter.



Burmese refugees

Artist: Maung Maung Tinn

¹ Gupte P. Can Asia's population bomb be defused? *Asia*.1983 Sept-Oct;6(3):16-23,43

² Pandey GD, Pandey J. Attitude towards vasectomy during post-emergency period: a study of family welfare workers in Uttar Pradesh. [abstract] *POPCEN News*. Lucknow:1979 Aug-Sept;5(4):1-5,16

³ Bodh Gaya, Bihar India, 1983. Author witnessed sterilization.

⁴ Paul VI. Encyclica Humanae Vitae, 1968, July 25, para.2, in Gremillion J (editor) *The Gospel of Peace and Justice*. New York: orbis, 1976

⁵ Gandhi MK. *An Autobiography—My Experiments with Truth*, Sewagram, Wardha, 1979;4,Ch.39

⁶ *ibid*

⁷ Egeroe B. How far can the 'demographic bonus' be a help to other developing countries? In *EDC News*, Ohlsson L (editor), Dept of Peace and Development Research, Goeteborg University;2004-03-25

⁸ Vajpayee AB. Inaugural Speech. National Commission on Population (government of India) New Delhi: July 22, 2000.

⁹ "[...]a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life."

¹⁰ Global Policy Committee of the WHO-2 May 1994, WHO Position Paper on Health, Population and Development for the International Conference on Population and Development, Cairo, 5-13 Sept. 1994.

¹¹ Helferich C. Zur Notwendigkeit einer lebenswelt- und lebenslaufbezogenen, interdisziplinären Perspektive, in BZgA (editor): *Kontrazeption, Konzeption, Kinder oder keine*. Dokumentation einer Expertentagung. Fachheftreihe Forschung und Praxis der Sexualaufklärung und Familienplanung 1996;Koeln, Vol.6: 7-14.

¹² Helferich C. *Life History and Family Planning*. Research and Practice of Sex Education and Family Planning; BZgA (Federal Centre for Health Education), (editor) Scientific Foundations, Cologne: 2002, Vol.13.3.

¹³ Scherr EF. U.S. backs "well-being" programs for women. An interview with Julia Taft, Assistant Secretary for Population, Refugees and Migration. *Glob Issues*. 1998 Sep; 3(2):11-4.

သားဖွားပြီးတိုင်း သားသမီးခြားယူရန် မိခင်နှင့်ဖခင် နှစ်ဦးလုံးကို အကြံပေး
ချော့နှေးပါ။



ဖိသန်အိန်ဖျော်ဝံ့တဘျီလင်္ဂလင်္ဂ ဟုန်ကူန်အိန်သက်း မိဂ်ဒီးပဂ်ခံဂ်လိာ်လာ ကဟံ
ယံၤထီၣ်ဖိအဆာအဂီၢ် တက့ၢ်.

ဖေါဟ်သးအံၣ်ဖျာ်ဟုန် မုမာဏေဝ်.ထါင်ဖေါဟ်လုံဟုာ ညေ လုံဟုာအိုခုံဆိုင်မုယါင်
ထင်းအိုဟုန်.စးလင်ဏးသေ့မေဝ်.ညေဖါ.ဧတီဟုာဏ် ။