Thailand-Burma Border Cross-border Reproductive Health Fact Sheet

There is a great need to address the reproductive health needs of people affected by the conflict in Burma. In 1989, with the opening of the Mae Tao Clinic this need began to be met on the Thailand side of the border, but need persisted amongst internally-displaced persons inside Burma. In 2000, community-based organizations along the Thailand-Burma border began providing cross-border reproductive health services to internally-displaced people in eastern Burma via an extensive network of workers ranging from traditional birth attendants to higher level medics able to provide basic emergency obstetric care interventions. In 2007, reproductive health coordinators from Burma Medical Association, Karen Department of Health and Welfare, Back Pack Health Worker Team, MOM Project, and Karen Women's Organization formed a "cross-border reproductive health coordination group," to exchange ideas on, and mutually support reproductive healthcare service provision in conflict-zones of Burma.

Reproductive Health Situation along the Thailand-Burma Border:

- The maternal mortality ratio among IDPs in eastern Burma is estimated to be 1,000-1,200 per 100,000 live births; the infant mortality rate is estimated at 91 per 1,000 live births[1]. Comparatively, MMR in Australia is 8 per 100,000 live births; IMR is 5 per 1,000 live births[2].

- In a survey (MOM Project) done in Karen, Karenni, Shan and Mon states in September 2006, unmet need for contraception was found to be above 60%. 88% of women reported a home delivery for their last pregnancy (<5 years). Skilled attendance at birth (5.1%) and any (39.3%) or > 4 (16.7%) antenatal visits, use of a bednet (21.6%), receipt of iron supplements (11.8%) was low.

- 50%-75% of maternal deaths worldwide are a result of post-partum hemorrhage (PPH), sepsis, eclampsia, obstructed labor, or abortion complications[3], all largely preventable with appropriate services.

- The WHO estimates that 47% of home births are assisted only by a traditional birth attendant (TBA), family member or by no one at all[4].

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[1] *BPHWT 2006 "Chronic Emergency" Report*

[2] *State of the World Population 2007, UNFPA*

[3] *Sibley L, et al. Obstetric first aid in the community--partners in safe motherhood. A strategy for reducing maternal mortality. Journal of nurse-midwifery. 1997*

[4] *Kruske S, et al. Effect of shifting policies on traditional birth attendant training. Journal of midwifery & women's health. 2004*

Org Name	Start Date	Total # of project sites	Total target population	Total # of TBAs	Total # of higher level medics
BPHWT	Jan 2000	76 (BP Teams) in 6 ethnic areas	160,000	~ 600	280 (normal BP medics only when TBA cannot deliver)
KWO	2002	3 IDP areas; 2 camps	30,000	102	5
BMA (MCH)	2005	9 (in 7 ethnic areas) + 6 sites proposed expansion	69,000	230	36
BMA (MOM)	July 2006	12 (in 4 ethnic areas)	61,382	284	149
KDHW	July 2007	15 (in Karen state)	48,000	216	26

Services Provided by Cross-border RH Programs

Services	BPHWT	KWO	BMA (MCH)	BMA (MOM)	KDHW
Fe/FA	X	X	X	X	X
Deworming	X		X	X	X
Paracheck	X (MCP)		X	X	X
ITN Delivery	X (MCP)		X (CDC)	X	X
Counseling (nutrition, neonatal, FP)	X	X	X	X	X
VDRL				X	
Hemoglobin			X	X	X
Urine Test			X	X	X
Vit A (maternal)	X	X	X	X	X
Vit A (neonatal)	X	X	X	X	X
Clean Delivery	X	X	X	X	X
Cord cutting w/clean blade	X	X	X	X	X
Cord Antisepsis	X	X	X	X	X
Neonatal Resuscitation (suction ball)	X	X	X	X	X
Misoprostol for PPH				X	X
Manual Vacuum Aspiration				X	
IM/IV Magnesium				X	
Manual removal placenta				X	
Blood donor screening and transfusion			X (not all areas)	X	
Antibiotics	X	X	X	X	X
Post Natal Care	X	X	X	X	X
Provision of family planning	X	X	X	X	X
Post Abortion Care	X	X	X	X	X