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SEPARATED BY BORDERS UNITED IN NEED

*An assessment of reproductive health on the
Thailand-Burma border*



Separated by borders, united in need

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LIST OF ABBREVIATIONS, ACRONYMS & KEY TERMS

ANC	Antenatal care	MOM	Mobile Obstetric Maternal Health Workers Project
ARC	American Refugee Committee	MOPH	Ministry of Public Health (Thailand)
ARH	Adolescent Reproductive Health	MSH	Mae Sot Hospital
ARHN	Adolescent Reproductive Health Network	MTC	Mae Tao Clinic
ARHZ	Adolescent Reproductive Health Zone	MVA	Manual vacuum aspiration
BMA	Burma Medical Association	NGO	Non-governmental organization
BPHWT	Back Pack Health Worker Team	Ob/Gyn	Obstetrics and gynecology
BWU	Burmese Women's Union	OCPs	Oral contraceptive pills
CBO	Community-based organization	PAC	Post abortion care
CHW	Community health worker	PNC	Postnatal care
CHV	Community health volunteer	PPAT	Planned Parenthood Association of Thailand
CPR	Contraceptive prevalence rate	PPH	Postpartum hemorrhage
EC	Emergency contraception	PU-AMI	Première Urgence-Aide Médicale Internationale
ECPs	Emergency contraceptive pills	PWO	Palaung Women's Organization
EmOC	Emergency obstetric care	RAISE	Reproductive Health Access, Information and Services in Emergencies
FBR	Free Burma Rangers	RH	Reproductive health
FGD	Focus group discussion	SAW	Social Action for Women
FP	Family planning	SDPC	State Peace and Development Council
GHAP	Global Health Access Program	SHC	Shan Health Committee
HW	Health worker	SHIELD	Support to Health, Institution Building, Education and Leadership in Policy Dialogue
Ibis	Ibis Reproductive Health	SMRU	Shoklo Malaria Research Unit
IDP	Internally displaced person	STI	Sexually transmitted infection
IOM	International Organization for Migration	TBA	Traditional birth attendant
IRC	International Rescue Committee	ULYO	United Lahu Youth Organization
IUD	Intrauterine device	UNHCR	United Nations High Commissioner for Refugees
KDHW	Karen Department of Health and Welfare	USAID	United States Agency for International Development
KWAT	Kachin Women's Association Thailand	WLB	Women's League of Burma
KWO	Karen Women's Organization		
KYO	Karen Youth Organization		
LARCs	Long-acting reversible contraceptives		
MAP	Migrant Assistance Program		
MCH	Maternal and child health		
MHW	Maternal health worker		
MMR	Maternal mortality ratio		



EXECUTIVE SUMMARY

Introduction

The region of eastern Burma is mired in conflict and human rights abuses. The former Myanmar military junta and the new civilian government, are responsible for widespread human rights violations throughout the region, including forced labor, extrajudicial killings, rape, forced displacement, imprisonment, and destruction of food supplies. The human rights situation in eastern Burma has resulted in the migration of millions throughout the region, leaving the population divided among isolated rural villages or internally displaced person (IDP) areas in eastern Burma, migrant communities in Thailand, and nine refugee camps in Thailand. **Reproductive health indicators throughout the region demonstrate lack of access to family planning resources, including sexual and reproductive health information, unmet contraceptive needs, and high rates of unplanned pregnancy, maternal mortality, and harm from unsafe abortion.**

Regional population breakdown: Cross-border populations, migrants, and refugees

The term “**cross-border populations**” is used in this report encompass those living in IDP areas, as well as villages in conflict-affected and rural areas in eastern Burma bordering Thailand. Displaced persons and those living in conflict-affected areas face ongoing security threats, economic isolation, and poverty.

Only persons fleeing conflict may register as refugees in the nine camps in Thailand, and there has not been an official registration since 2005. At least 80% of those that have illegally entered Thailand as **migrants** are from Burma, and an estimated quarter million are suspected to have fled Burma because they are victims of human rights violations. Hundreds of thousands of unregistered migrants live in Thailand, working in factories and in agriculture, in settings characterized by poor living conditions, without access to basic needs such as clean water, sanitation, and healthcare.

Over 140,000 Burmese **refugees** and asylum-seekers live in nine camps in Thailand, in one of the most protracted refugee situations in the world. Within the camps, refugees receive basic food, shelter, education, and medical care. Most arrivals since 2005 are not registered, and the registered camp population is significantly smaller than the actual camp population.

Project aims & objectives

The purpose of this needs assessment was to identify and discuss the unmet reproductive health needs of cross-border, migrant, and refugee populations living in the Thailand-Burma border region. The project focused on unmet contraceptive needs, maternal mortality, and unsafe abortion. The report is intended to serve as a tool for collaboration and information-sharing among community-based organizations (CBOs) and non-governmental organizations (NGOs) working in the Thailand-Burma border region. The report is also intended to service as a resource for potential funders.

Methods

This assessment is based on a multi-methods design completed by researchers from Ibis Reproductive Health (Ibis) and Global Health Access Program (GHAP). Ibis and GHAP researchers conducted interviews with stakeholder organization representatives, reviewed and synthesized local organizations' statistics and data, completed a service mapping exercise, and conducted focus group discussions (FGDs) with migrants and healthcare workers. Ibis and GHAP researchers interviewed representatives from ten organizations serving cross-border populations, 14 organizations serving migrant populations, and four organizations that serve seven of the nine refugee camps. Post-interview follow-up was carried out with representatives from individual organizations to confirm statistics. The project team also conducted 18 FGD with unmarried adolescents, married adults, and healthcare workers in different communities along the Thailand-Burma border.

Assessment findings: Cross-border populations

Access to family planning counseling and supplies is limited

Populations living in eastern Burma have very little access to family planning counseling, and available information is limited to educational information about contraception options. There is a bias—cultural and religious—reported among some CBOs that may deter adolescents from seeking and accessing family planning supplies and counseling. Because of barriers to access in eastern Burma, a number of organizations provide family planning supplies through both freestanding clinics and the deployment of mobile healthcare workers. The most commonly dispensed methods of contraception are male condoms, oral contraceptive pills (OCPs), and hormonal injections.

Knowledge and use of emergency contraceptive pills (ECPs) is low

Use of emergency contraception among cross-border populations is characterized by lack of knowledge. Misinformation about the use timeframe, regimen, eligibility, and side-effects is common. Few organizations serving cross-border populations dispense ECPs, many health workers do not know how to administer the medication, and many community members are not familiar with ECPs and therefore do not know to request the medication.

Access to family planning procedures is virtually non-existent

There is virtually no access to family planning procedures—including intrauterine device (IUD) and hormonal implant insertion and sterilization procedures—among cross-border populations in eastern Burma. All of these procedures are purportedly provided at government hospitals in Burma, but due to structural barriers and distrust of Burmese hospitals, there is no evidence that these populations have access to these services. Furthermore, there is concern among cross-border organizations that because of ongoing security concerns, IDP women living in conflict-affected areas will not return to have their IUDs removed in a “sterile” setting. Maternal and child health workers in cross-border clinics are not trained in IUD or implant insertion or removal, vasectomy, or tubal ligation, and few sites along the border are able to refer patients living in eastern Burma to Thai hospitals or to Mae Tao Clinic (MTC).

Common barriers to family planning counseling, supplies, and procedures include distance, lack of funds, distrust

of hospitals in Burma, lack of information and education about reproductive health, common misperceptions about contraceptives and family planning methods, lack of support of cross-border community leaders, barriers imposed by age, marital status or gender, and lack of consistency and reliability of supplies and trained healthcare workers.

Lack of access to skilled birth attendants, postpartum hemorrhage, and unsafe abortion are major contributors to maternal mortality

Because of the region’s isolation, risks in delivering care to conflict-affected areas, and logistical challenges, maternal mortality rates in eastern Burma dwarf the rate in Thailand and Burma as a whole. Maternal deaths are the result of lack of access to skilled birth attendants and a lack of knowledge about emergency obstetric care among local untrained traditional birth attendants (TBAs). Post-partum hemorrhage and unsafe abortion are the most commonly reported causes of maternal mortality and morbidity for cross-border populations.

Challenges to reducing maternal mortality among cross-border populations include insufficient medic training and high medic turnover, lack of sustainable supplies, communication difficulties between untrained TBAs and medics, and logistical challenges in the movement of medics, trainers, and supplies. Organizations serving cross-border populations have responded to these challenges by adopting community-level and/or mobile service delivery models and training medics, TBAs, and other health workers to deliver essential clinic- and home-based reproductive healthcare in eastern Burma.



Women lack access to safe and legal abortion care and TBAs perform unsafe procedures

There is virtually no access to safe and legal abortion in Burma. There are mixed reports of abortion practices and prevalence in Burma; however organizations and individuals report that unsafe abortion is common. Methods of unsafe abortion include abdominal massage, consumption of malaria medications, insertion of a packet of plants into the vagina, use of “traditional” medicines, and insertion of a stick, fishing hook, or other instrument into the vagina. Abortions are most often performed by untrained TBAs, and the associated health risks noted by organizations and FGD participants include incomplete abortion, infection, fever, bleeding, pain, weakness, and death. Organizations often related the issue of unsafe abortion to lack of access to family planning among cross-

border populations. Virtually all respondents reported community disapproval of induced abortion.

Assessment findings: Migrants

Access to family planning counseling, supplies, and procedures is limited

There is very little access to family planning counseling in migrant communities and migrant access to family planning supplies is limited. NGOs and CBOs often include peer education, workshops, and individual or group discussions in their overall programs. Access to family planning supplies is mostly gained at MTC, through CBO outreach, and at drop-in centers such as the Adolescent Reproductive Health Network Youth Center. The most commonly available forms of contraception are OCPs and male condoms. Thai clinics also offer family planning supplies; however, migrant workers often cannot access these facilities due to distance, security checkpoints, time away from work, financial constraints, and distrust of Thai Ministry of Public Health facilities. There is very little knowledge about ECPs in the migrant community and among healthcare providers that serve migrants. Lack of knowledge is reported as the most common barrier to emergency contraception use.

Family planning procedures—including IUD and implant insertions—are available at Thai hospitals, but are only free of charge for those migrants with work permits or ID cards. Some organizations expressed apprehension about the use of implants and IUDs among migrant women based on past cases of women removing implants outside sterile settings and the expense of offering implants and IUDs as compared with other forms of contraception. Meanwhile, pervasive misinformation about family planning procedures prevents many from using these methods.

Common barriers to family planning counseling, supplies, and procedures in the migrant community include biases based on age, gender, and marital status, security threats, lack of knowledge, distance to health centers, distrust of Thai health centers, resource constraints and lack of sustainable access to supplies, and widespread misinformation about family planning.

Structural barriers contribute to high rates of post partum hemorrhage, induced abortion, and malaria, which are major contributors to maternal mortality

Post partum hemorrhage, induced abortion, and malaria are reported as the most common direct and indirect causes of maternal mortality among migrants. Migrants who deliver at home usually do so with a TBA, and access to a skilled birth attendant is available at Thai hospitals, MTC, or one of three Shoklo Malaria Research Unit migrant clinics. Women that need to reach emergency obstetric care reportedly do so only after overcoming structural barriers, including security, language, and financial constraints.

Unsafe abortion is widespread

Given the legal status of abortion in Thailand and attitudes about abortion in the migrant community, abortion prevalence is hard to estimate. However, organizations and individuals report that unsafe induced abortion is widespread in the border region. According to organizational interviews and FGD participants, induced abortions in the migrant community are most often performed by untrained TBAs, family members, or by women themselves. In 2009, MTC saw 15% of obstetrics and gynecology admissions related to post abortion care (PAC). Reported health risks of unsafe abortion in the migrant community include infection, hemorrhage, perforation, bleeding, and death.

Assessment findings: Refugees

Camp-based clinics provide family planning services, but age, marital status, and misconceptions limit access

Camp-based clinics provide counseling for family planning methods and serve as an access point for family planning supply distribution. Camp-based organizations distribute OCPs, hormonal injections, and male and female condoms. Referrals to Thai hospitals are available for IUDs, vasectomy, and female sterilization although

very few individuals choose these methods. Commonly reported challenges to family planning counseling, supplies, and procedures access among refugees include biases regarding age and marital status and widespread misconceptions about contraception and sterilization.

Knowledge and distribution of ECPs in camps is limited

ECPs are not widely used and there are numerous barriers to accessing ECPs in the camps. First, organizations report that camp culture does not embrace the use of ECPs in all eligible circumstances. There is a bias against providing ECPs to women in the camps without first determining whether her case represents an adequate “emergency.” Furthermore, there is widespread concern about perceived misuse of ECPs, including non-evidence based fears about repeated use and side-effects.

Women may access a skilled birth attendant at camp-based clinics

Women may access a skilled birth attendant at NGO-run clinics inside the refugee camps. However, despite access to clinic-based skilled birth attendants, maternal mortality within camps is likely higher than in Thailand as a whole.

Unsafe abortion is common and referrals to Thai health centers are limited

As with cross-border and migrant populations, information about abortion prevalence in refugee camps is challenging to determine. Abortion is strongly opposed by camp religious and community leaders. Interview respondents reported that the community will “blame and shame” women who terminate their pregnancies. Health risks of unsafe abortion reported by CBOs include heavy bleeding, loss of consciousness, and death. The only access to safe abortion for refugee women is referral to a Thai hospital, should that patient fall under one of the exceptions under Thai law. However, although termination of a pregnancy that resulted from rape is allowed under Thai law, the Planned Parenthood Association of Thailand reports that abortion referrals for rape cases are extremely difficult because health service providers of require the involvement of Thai authorities.

Assessment recommendations

Report findings center on six areas identified by stakeholder organizations and Ibis and GHAP researchers. Priority areas for funding and strategic planning include the following:

Family planning information, counseling, supplies, and procedures: Respondents from all three communities overwhelmingly reported lack of knowledge about reproductive health and family planning as one of the biggest reproductive health issues in their communities. Funding priorities should include resources to ensure sustainable organizational access to family planning supplies and to scale-up education and outreach activities, including yearly trainings of peer educators, particularly for adolescents.

Undertake efforts to increase awareness of and access to emergency contraception: Use of ECPs is low among all three populations in the region. Health workers, program managers, and community members—particularly in migrant and cross-border settings—lack adequate knowledge to dispense and request ECPs in accordance with evidence-based practices, while camp-based clinics have adopted policies that do not make the pills accessible for all women who could benefit from ECPs to prevent pregnancy. Overall, more information and education are needed for both the public and stakeholder organizations.

Increase access to skilled birth attendants: Given the numerous challenges facing organizations in the cross-border setting, sustainable, multi-year funding that includes organizational core costs is crucial for long-term interventions to reduce maternal mortality in eastern Burma by expanding women’s access to skilled birth attendants.

Develop strategies to reduce harm from unsafe abortion: Harm from unsafe abortion continues to serve as

a significant factor in maternal mortality and morbidity across the region. In particular, there is a need for a comprehensive dialogue among program managers and community leaders about unsafe abortion in migrant and cross-border areas. Furthermore, for all three populations, the greatest barrier to safe abortion care is lack of access to legal abortion providers. Without increased access to safe and legal care, unsafe abortion will continue to be a presence in the region. There appears to be a significant need to identify and institutionalize mechanisms to increase women's timely access to safe and legal services.

Expand efforts to address adolescent reproductive health (ARH) needs: Among all three populations, availability of family planning counseling and services for adolescents and unmarried adults is variable among those organizations that are not specifically ARH focused. There is a need to support efforts to strengthen capacity building efforts, increase service visibility, and foster coordination among all organizations that provide RH services and interface with adolescents, particularly for existing ARH networks and service delivery organizations.

Establish additional avenues for communications and coordination: The success of joint projects among stakeholder organizations emphasizes the importance of coordination. Priority areas for enhancing border-wide communication and collaboration include support for data collection and sharing. The sharing of both data and program outcomes could inform model interventions and encourage evidence-based practices in the region. Additional donor support is needed for reproductive health coordination in the Thailand-Burma border region.

Conclusion

Our findings demonstrate a pervasive lack of access to family planning resources, the need for increased access to skilled birth attendants, and harm from unsafe abortion among all three populations. While addressing gaps in reproductive health will require overcoming seemingly impossible regional challenges, organizations have made demonstrated headway in improving health outcomes, even while working in the constraints of this setting. The Thailand-Burma border encompasses some of the most vulnerable populations in the world, and while organizations continue to implement successful projects to improve reproductive health in the region, support from a broader community of organizations and funders is imperative to address unmet reproductive health needs for all three populations.





BACKGROUND & INTRODUCTION

Description of the populations living on the Thailand-Burma border region

The region of eastern Burma is mired in conflict and human rights abuses. Though the Burmese military junta has recently ceded to a civilian government, the military rulers under the State Peace and Development Council (SPDC) are responsible for widespread human rights violations throughout the region, including forced labor, extrajudicial killings, rape, forced displacement, imprisonment, and destruction of food supplies. The human rights situation in eastern Burma has resulted in the migration of millions throughout the region, leaving the population divided among isolated rural villages and internally displaced person (IDP) areas in eastern Burma, and migrant communities and refugee camps in Thailand. A map of the region is included as Appendix A.

Cross-border populations

The term “cross-border populations” is used in this report to encompass both those living in IDP areas, as well as those living in villages in conflict-affected and rural areas in eastern Burma who are not technically displaced. Cross-border populations face ongoing security threats, economic isolation, and poverty. Decades of conflict between the SPDC and ethnic minority groups in eastern Burma have resulted in the displacement of hundreds of thousands of people and the destruction, forced relocation, or abandonment of over 3,600 villages since 1996 [1]. Since 2009, conflict—particularly in Karen State, and more recently Shan State and Kachin State—has intensified; an estimated 26,000 persons were displaced during conflict in the weeks surrounding the elections in November 2010 [1]. It is estimated that at least 446,000 IDPs live in the eastern border region of Burma and Thailand [1]. IDP populations are comprised mostly of ethnic minorities such as Karen, Karenni, Mon, Palaung, Lahu, and Shan peoples. Meanwhile, communities in eastern Burma that have not faced forced relocation or displacement nonetheless face economic isolation and dangers inherent in a region hindered with long-term regional conflict. These areas are considered among the poorest and most vulnerable in the country [1].

Migrants

Thai law allows for those fleeing fighting or political persecution to apply for refugee status, but not those fleeing other abuses such as forced labor, forced relocation and other human rights violations [2,3]. However, there is evidence that in practice Thailand is more lenient in its consideration of refugee status determination. Although limits on who may register, coupled with registration restrictions (no formal registration has taken place

since 2005), have prevented many from becoming registered refugees, individuals that nonetheless continue to cross the border from eastern Burma into Thailand are presumably genuine asylum seekers [1]. There are approximately 2-3 million migrant workers in Thailand [1]. At least 80% of these migrants are from Burma [1], and an estimated quarter million is suspected to have fled Burma because they are victims of human rights violations [4]. Hundreds of thousands of unregistered migrants live in Thailand, working in factories and in agriculture, in settings characterized by poor living conditions, and lack of access to basic necessities such as clean water, sanitation, and healthcare.

Refugees

Over 140,000 Burmese refugees and asylum-seekers live in nine camps in Thailand, in one of the most protracted refugee situations in the world [5]. Within the camps, refugees receive basic food, shelter, education, and medical care. However, under Thai law, refugees found outside the camps are subject to arrest and deportation [5]. Most arrivals since 2005 are not registered, and the registered camp population is significantly smaller than the actual camp population [6]. In June 2011, there were 92,395 refugees registered with the Ministry of Interior and United Nations High Commissioner for Refugees (UNHCR), while the total verified caseload was 147,019 [6].

Reproductive health indicators on the Thailand-Burma border

Family planning

Reproductive health (RH) indicators demonstrate lack of family planning (FP) resources, including education, supplies, and services. Throughout the region, these indicators include a lack of sexual and reproductive health education, unmet contraceptive needs, and high rates of unplanned pregnancy and unsafe abortion. Whereas the contraceptive prevalence rate (CPR) in Thailand is estimated at 72% [4], and 37% for Burma as a whole [7], there is an unmet need of around 60% [8,9] among IDPs in eastern Burma. An estimated 80% of women in eastern Burma have never used contraceptives [9]. Another survey found that only 22% of female respondents in eastern Burma used any form of modern contraception [10]. In the five refugee camps served by the Planned Parenthood Association of Thailand (PPAT), the CPR ranged from 18% to 39% in 2009 [11].

Context: Incentives to have children among ethnic minorities in eastern Burma

Organizations and individuals report that ethnic conflict and high infant mortality among cross-border populations has created an incentive among some groups to have large families. According to one organization, some cross-border populations “don’t want to use the family planning because they are afraid if their children die from cholera or dengue they will not have any more children.” Furthermore, the status of many cross-border populations, migrants, and refugees as ethnic minorities provides a cultural incentive among some groups to increase population size. Some ethnic bodies, such as the Kachin Independence Organization, have instituted formal pro-natalist policies specifically to oppose SPDC policies to decrease ethnic populations.

Maternal mortality

Maternal mortality ratios vary considerably among communities in the Thailand-Burma border region. The Thailand maternal mortality ratio (MMR) is estimated at 44 per 100,000 live births [12], while the MMR in Burma as a whole is estimated at 240 [10] to 400 [13] per 100,000 live births. In eastern Burma as a whole, the MMR is 721 per 100,000 live births [10], and in areas served by the Back Pack Health Worker Team (BPHWT)—conflict-affected areas and IDP areas—the MMR is estimated at 1000 to 1200 per 100,000 live births [9]. The higher MMR in IDP areas reflects the human rights abuses carried out by the SPDC in the region and lack of access to skilled birth attendants, particularly in areas systematically cut off from food, funding and information under the SPDC “Four Cuts” policy, and where incidents of forced displacement and other abuses are widespread [14].

Organizations report that maternal death among migrants is less than reported among cross-border populations because of proximity to skilled birth attendants at Thai hospitals and community-based organization clinics like Mae Tao Clinic (MTC). However, migrants in Thailand face serious structural barriers to accessing emergency obstetric care (EmOC), as well as high rates of unsafe abortion, with women often seeking care only when complications are severe. This situation has led to a higher rate of maternal mortality among migrants than the Thai population as a whole.

Unsafe abortion

The abortion law in Burma is highly restrictive, allowing for abortion only to save the life of the pregnant woman [15], while Thailand's law provides for exceptions to preserve the physical and mental health of the woman and in cases of rape [16]. Under the Thai criminal code, abortion is legally permissible when "necessary" for the physical or mental health of the pregnant woman, and when the pregnancy is the result of a sexual offense such as rape or incest. Women who conceive at or under the age of 15 also qualify for abortion under the law because they are under the age of consent.

Unsafe abortion has a significant impact on maternal mortality in Burma, accounting for at least half of all pregnancy-related deaths [17]. In addition to the risk that unsafe abortion poses to women in eastern Burma, it is also a significant problem among Burmese women living in Thailand. On average, 500 women seek post-abortion care each year at MTC, a free clinic serving patients from Burma in Tak province, Thailand [18]. These patients represent 15% of all obstetrics and gynecology (Ob/Gyn) patients treated at the clinic each year [19]. One researcher based at the clinic has asserted that the actual morbidity associated with unsafe abortion is much higher because most women induce abortions at home and due to structural barriers to care, most women only seek post abortion care once their health situation is dire [18]. Though few RH studies have examined abortion among migrant populations, the Thai Ministry of Health has reported that the rate of abortion is 2.4 times higher among Burmese migrants than for the local Thai population, and that most abortions are performed by untrained traditional birth attendants (TBAs) and lay midwives [17].

Context: Abortion law & and access to safe abortion in Thailand

Background: Thai abortion law

Under the Thai Criminal Code, Section 305, a woman may only receive an abortion from a physician to preserve her health, including cases in which the woman's life is endangered by the pregnancy, or when the pregnancy is a result of rape. Under the Criminal Code, Sections 276-284, women who conceive at or under the age of 15 may also receive an abortion because they are unable to consent to sex, thereby falling under the rape exception in Section 305. The Thai Medical Council has issued regulations further outlining and refining when women may legally access abortion in Thailand. Under these regulations, only a physician as defined by the Medical Professional Act may provide an abortion. Abortion care may be provided when necessary due to a physical health or mental health "problem" of the pregnant woman. At least one physician other than the one performing the abortion must certify or approve that the woman's mental or physical health condition meets the level of necessity required under the regulations. In addition, the Thai Medical Council has interpreted the "severe stress" of known or high risk of fetal anomaly, severe genetic disease, or disability, as providing a medically necessary indication for abortion under the mental health exception.

Access to safe abortion care in Thailand

Despite the significant role that unsafe abortion plays in maternal mortality and morbidity, there is a consensus among stakeholders that it is difficult for women to access abortion care in Thailand, even if they fall under one of the legal indications for abortion. Noted barriers to access include lack of facilities and providers, concern among providers about the law and its interpretation, and reluctance among providers to perform abortions based on personal moral or religious objections.

PROJECT AIMS & OBJECTIVES

The purpose of this needs assessment was to identify and discuss the unmet reproductive health needs of cross-border population, migrants, and refugees living in the Thailand-Burma border region. The project focused on unmet contraceptive needs, maternal mortality, and unsafe abortion. The report is intended to facilitate collaboration and information-sharing among community-based organizations (CBOs) and non-governmental organizations (NGOs) working in the Thailand-Burma border region, and to inform potential funders of the continued need for dedicated resources for these populations.

METHODS

The project's goal was to integrate information gained from qualitative interviews with available data to present an overall picture of the need for reproductive health services on both sides of the border. Ibis Reproductive Health (Ibis) and Global Health Access Program (GHAP) researchers conducted stakeholder interviews with representatives from NGOs and CBOs engaged in reproductive health work with cross-border populations, migrants, and refugees. The project team also reviewed and synthesized local organizations' statistics and data and completed a service mapping with institutional stakeholders. Thailand-based groups like MTC, the Burma Medical Association (BMA), and various camp-based clinics record extensive information about the health of the populations they serve. Post-interview follow-up was carried out with individual organizations to confirm statistics.



The project team also conducted structured focus group discussions (FGDs) in migrant areas around Mae Sot and Phop Phra Districts in Tak Province, and in Chiang Mai. Focus group discussions were conducted with unmarried adolescents, married adults, and healthcare workers in order to gain varied perspectives and learn about the experiences of individuals in different communities. This ultimately led to a more robust assessment of need and was used to complement the information collected from NGOs and CBOs. Ibis and GHAP researchers facilitated nine FGDs with migrant adolescents in Mae Sot, Phop Phra, and Chiang Mai, totaling 87 adolescents. Six FGDs were conducted with 60 migrant adults in Chiang Mai and Mae Sot, and three FGDs with 30 healthcare workers were conducted in Mae Sot and Chiang Mai.

STAKEHOLDER ORGANIZATIONS & OVERVIEW OF SERVICES

Cross-border populations

Ibis and GHAP researchers interviewed ten organizations that provide reproductive healthcare and services to cross-border populations^a. These organizations provide reproductive health services to those living in IDP, conflict-affected, and rural areas in eastern Burma. Burma is one of the most diverse countries in the world, and many organizations working with cross-border populations target services to a particular ethnic group or groups. Organizations delivering care to cross-border populations face numerous security and logistical challenges in reaching this population, including dangers posed by the SPDC and other armed forces, distance, landmines, confiscation of medical supplies, and the risk of arrest or attack [20].

Stakeholder organizations serving cross-border populations

Back Pack Health Worker Team (BPHWT)
Burma Medical Association (BMA)
Partners/Free Burma Rangers (Partners/FBR)
Karen Department of Health and Welfare (KDHW)
Karen Women's Organization (KWO)
Karen Youth Organization (KYO)
Mae Tao Clinic (MTC)
Palaung Women's Organization (PWO)
Shan Health Committee (SHC)
United Lahu Youth Organization (ULYO)

Multi-state

The **Mobile Obstetric Maternal Health Workers Project (MOM)** is a community-based joint project between Johns Hopkins Center for Public Health and Human Rights, MTC, BMA, four local ethnic health departments (Karen Department of Health and Welfare [KDHW], Shan Health Council [SHC], Mon Health Department, and Karenni National Health Organization), and GHAP. MOM uses a three-tiered approach to increase access to essential RH services, including EmOC, antenatal care (ANC), postnatal care (PNC), and family planning services [21,22]. The MOM Project operates 12 sites in Karen, Karenni, Shan, and Mon States in eastern Burma, overseeing the development of a network of Maternal Health Workers (MHWs), Health Workers (HWs), and TBAs to provide skilled, mobile, and often home-based care to women and families [21]. TBAs and HWs work directly in communities and receive technical support and oversight from MHWs. MHWs receive a six-month training at MTC and travel to Thailand twice each year to restock supplies and receive follow-up training.

The **BPHWT** operates three programs: the Medical Care Program, the Maternal and Child Health Care Program, and the Community Health Education and Prevention Program. In 2010, BPHWT provided healthcare in 20 field areas, and there are currently a total of 1,259 BPHWT health workers living and working in Burma for these three programs: 254 medics, 645 TBAs, and 360 village health volunteers [20]. BPHWT teams of 3-5 health workers provide primary medical care, community health education and prevention, and maternal and child health (MCH) services. There are currently 80 MCH teams assigned to target Mon, Karen, Karenni, Kayan Kayah, Lahu, Shan, and Palaung areas, covering a catchment population of approximately 190,000 persons [23]. BPHWT teams return to Thailand for training and to re-supply twice per year and spend the remainder of the year living and working in target areas in Burma.

BMA operates 26 Sites in conflict-affected Mon, Karen, Karenni, Kayan, Shan, Palaung, Kachin, and Rakhine areas in Burma, representing a catchment population of 150,255. BMA served as a coordinating entity for the MOM Project, and staff for these sites includes 138 reproductive health workers and 456 TBAs.

^a Partners and Free Burma Rangers (FBR) are two separate organizations that partner for service delivery in eastern Burma. Stakeholder interviews were conducted with Partners, and FBR referred Ibis and GHAP researchers to Partners for information about their cross-border reproductive health activities.

Shan State

Lahu villages in the conflict-affected area of eastern Shan State near Kyaing Tung, Mong Phyak, and Mong Hsat are served by **United Lahu Youth Organization (ULYO)**. ULYO offers free services to those living in this conflict-affected area and reported that its three peer educators trained 22 youth in 2005 and 2007. As discussed below, Lahu areas are also serviced by two teams of BPHWT medics, covering a population of 4,667 persons [20].

Palaung villages in conflict-affected areas in Northern Shan State (Nam Kham, Man Tong, Man Hsan, Muse, Lashio, Kute Kai, Kyauntmae, Namatu), are served by **Palaung Women's Organization (PWO)**, which reported conducting adolescent reproductive health (ARH) trainings with 246 youth since 2005. These trainings were conducted by PWO's six peer educators, and included information on reproductive anatomy and physiology, gender issues, sexually transmitted infection (STI)/HIV prevention, family planning, consequences of unsafe abortion, and peer counseling.

Shan IDP camps on the Thai border in Shan State are serviced by SHC with support from organizations such as BMA and MTC. There are two Shan clinics in central and northern Shan State supported by MTC through the **RAISE Initiative** (Reproductive Health Access, Information and Services in Emergencies Initiative) [24]. The RAISE Initiative was launched at MTC and BMA in 2007 to facilitate trainings for medics from eastern Burma. RAISE Initiative trainings have included an eight-month training for health workers from Burma at MTC, covering EmOC, family planning, STI treatment, and gender-based violence. RAISE operated a total of six sites throughout eastern Burma until the project's close in March 2011.



Karen State

Populations within Karen State receive reproductive health services through Karen Youth Organization (KYO), BPHWT, KDHW, Karen Women's Organization (KWO), and Partners/Free Burma Rangers (FBR). **KYO** targets IDP and conflict-affected areas of Karen State, employing three peer educators that have trained 89 youth since 2005. The **KDHW** operates 32 clinics in conflict-affected areas of Karen State, 12 of which have a RH or FP program, with specialized reproductive health workers on-site. KDHW was one of four ethnic health departments to work on the MOM Project, and the four KDHW clinics that participated in MOM continue to provide RH services supported by

BMA, in addition to the 12 clinics with RH/FP services managed by KDHW. **KWO** has conducted ARH trainings in IDP areas of Karen State (Ah Pah Gyi and Dooplaya Districts), and trained 167 adolescents since 2005. **Partners/FBR** provides EmOC training, family planning supplies, and medications within Karen State, as well as resource and logistical support for seven KDHW clinics, which see an average of 300 patients per month. Partners/FBR have also established an IDP patient referral system in an effort to connect individual patients to better diagnostic or surgical services in Mae Sot, Mae Sariang, and Chiang Mai. There were six reproductive health referrals in the first six months of 2010 under this system. Karen State is further served by BPHWT mobile health teams, with over half of BPHWT’s teams based in Karen State [23].

Migrants

In addition to the approximately 140,000 Burmese refugees living in refugee camps along the Thailand-Burma border, it is estimated that hundreds of thousands more live in Thailand as unregistered migrants. Ibis and GHAP researchers conducted interviews with 14 organizations that engage in reproductive health work in the migrant community along the Thailand-Burma border. There are two overarching service models that organizations follow to deliver reproductive healthcare to migrants in the region. First, organizations like MTC, Social Action for Women (SAW), and Migrant Assistance Program (MAP) provide a channel of access to care that operates parallel to the Thailand public health system and existing Thailand-based private healthcare infrastructure. In the second service delivery model, NGOs partner with the Thai Ministry of Public Health (MOPH) to provide healthcare to migrants in Thailand. As compared with organizations serving cross-border populations, groups serving the migrant community tend to serve a broader population rather than targeting their services toward a particular ethnic group.

Organizations operating parallel services for migrant populations

Mae Tao Clinic, located in Mae Sot, is a nonprofit health clinic established in 1989 that provides healthcare to Burmese migrants and cross-border populations. The total catchment population is 150,000 migrants in the Mae Sot area, and 50,000 cross-border individuals in eastern Burma. Reproductive health services provided by MTC include PNC, ANC, obstetrics and delivery, including EmOC, post abortion care (PAC), and FP counseling and supply distribution. Among organizational interviews and FGDs, MTC was named the primary facility for the referral of patients. MTC provides care at no cost to its patients.

SAW operates in Mae Sot and in ten surrounding migrant areas^b. SAW’s reproductive health work includes ARH training for youth aged 15-24. This training curriculum includes anatomy and physiology, gender issues, HIV/STI prevention, family planning, consequences of unsafe abortion, and peer counseling. SAW has trained 212 youth in Mae Sot migrant communities since 2005. SAW also distributes family planning supplies and trains peer educators to serve as a link between SAW and the migrant community in order to increase access to family planning counseling and supplies.

Burmese Women’s Union (BWU) provides family planning counseling, health education and group discussion, and distributes supplies in migrant areas in Mae Sot, including Mae Tao Pet, Pa De, Mae Ku, and Ban Mai. BWU’s staff of nine serves approximately 30-40 family planning clients each month. Kachin Women’s Association of Thailand (KWAT) operates a drop-in center in Chiang Mai, where they hold group discussions, distribute FP supplies, and

Stakeholder organizations serving Burmese migrant populations

BWU (Mae Sot)
 IOM (Mae Hong Son)
 IRC (Border-wide)
 KWAT (Chiang Mai)
 MAP (Mae Sot and Chiang Mai)
 MTC (Mae Sot)
 PPAT (Mae Sot and Chiang Mai)
 SAW (Mae Sot)
 SMRU (Mae Sot)
 Tin Tad Clinic (Fang)
 WLB (Chiang Mai, Hang Don)
 World Vision (Mae Sot)

Coordinating CBO networks

ARHN (Mae Sot)
 ARHZ (Chiang Mai)

^b Mae Tao Pet, Ban Mai, Kwa Ka Loe, Mae Ku, Mae Pa, Ka Pi Ban, Ton Town, Mae Tao Mine, Hua Fai, Ha Town

have a library and computers available for area migrants. KWAT also holds cross-border ARH trainings along the Thai border with Shan State twice yearly as funding allows.

Migrant Assistance Program (MAP) serves migrant areas in Mae Sot^c and Chiang Mai^d. MAP has seven volunteers, five peer educators, and two full-time employees in Mae Sot, where RH activities include trainings on HIV prevention, outreach, peer education, referrals, basic RH trainings, FP supply distribution, and radio-based health education programs. MAP runs a similar program in Chiang Mai, where their five staff members, ten peer educators, and 15 volunteers work in eight districts with a catchment population of 50,000-60,000 migrants. Most migrants in these eight areas are Shan and Lahu. MAP also conducts outreach with adolescents in the Mae Sot area. MAP has operated a drop-in center in Mae Tao Mine since 2004, where migrants may access a library, HIV trainings, and free condoms. Other outreach includes a bi-monthly one-hour radio program about reproductive health. RH outreach includes information on how to use and obtain oral contraceptive pills (OCPs), hormonal injections, and male condoms. Monthly HIV and RH outreach is coupled with distributions of OCPs and male condoms to 960 migrants who work in factories. MAP refers patients to MTC and Mae Sot Hospital (MSH) for treatment. Finally, MAP operates three drop-in centers in the Chiang Mai area. One facility is for patient treatment, while two serve as resource centers and include a library, activities for adolescents, HIV/STI testing, and condom distribution. MAP also negotiates transportation and treatment cost for migrants to access services at local Thai hospitals.

Organizations operating in partnership with the Thailand Ministry of Public Health

The **Tin Tad Clinic**, located in Fang District, serves Shan migrants and a limited number of cross-border IDPs. The clinic reports that there are approximately 23,000 to 25,000 migrants in Fang, Chai Pagan, and Mai Ai districts. The clinic partners with the Thai MOPH to deliver services to migrants, and is recognized by the Thai MOPH as a sub-rural health center. Between July and December 2009, the Tin Tad clinic saw 3,534 clients, including 591 FP clients. Other RH services offered by the Tin Tad Clinic include HIV testing, referrals for HIV positive patients to the Thai district hospital in Fang, home health worker visits for PNC, FP information and education, and FP outreach to communities that cannot reach the clinic. The staff includes one fieldworker and one trainee, a senior medic, two junior medics, two health workers, and six trainees who are participating in a six-month training. The clinic does not provide obstetric care, and referrals are provided to Thai clinics and hospitals for deliveries and ANC.

The **SHIELD Project** (Support to Health, Institution Building, Education and Leadership in Policy Dialogue) is a joint project operating in five provinces throughout north and west Thailand, and two provinces in central Thailand^e. SHIELD works closely with the Thai MOPH and Provincial Public Health Offices to advocate for the provision of health services to migrants at provincial health centers and health posts, and to strengthen the linkages between Thai health providers and migrant communities in Chiang Mai, Chiang Rai, Tak, Samut Prakarn, Mae Hong Son provinces and Bangkok [25]. The project directly benefits 81,000 Burmese migrants through SHIELD's network of 81 border health workers, 49 health centers, and 41 health posts, and has assisted 834,643 patients since 2009^f.

The **International Rescue Committee (IRC)** manages the health portion of the SHIELD Project, and works directly with the Thai MOPH to fill gaps in the healthcare system for migrants. As part of the SHIELD Project, IRC's Migrant Health Program provides sub-grants to local organizations to fill gaps in service, and supports the MOPH through the Provincial Health Office. Family planning services available to migrants at Thai government health centers and health posts include FP counseling, FP supply distribution, and FP procedures. In the border region, MTC is an important SHIELD partner, providing over 100,000 annual consultations [9]. The SHIELD Project ended a

^c Mae Tao Mine, Mae Ku, Ka Bi Ban, Pa Deng, Bon Twe, Tam Sia, Mae Tao Tite, and Hua Fai

^d Muan, Han Don, Sala Pit, Sankapen, San Sai, Doi Saket, Mae Rim, and Chang Dao

^e Mae Hong Son, Chiang Mai, Chiang Rai, Tak, Ratchaburi, Bangkok, and Samut Prakarn

^f This information was contained in an unpublished report that the study team received from a key informant interview in Mae Sot, October 22, 2010.

five-year United States Agency for International Development (USAID) grant in November 2010 and entered its second phase in 2011.

One key component of the SHIELD project involves the recruitment, training, and support of community health workers (CHWs) and community health volunteers (CHVs). Migrant health volunteers engage in activities related to vaccinations, disease control, nutrition, and general migrant health. Reproductive health outreach includes FP counseling and supply distribution, MCH services, and PNC. Family planning counseling and supply distribution specifically targets women after childbirth and as part of standard treatment for PAC.

In total, there are SHIELD health outposts based in 35 of the 300 to 500 factories in the Mae Sot and Phop Phra areas. Resource constraints and factory owners' willingness to allow for the project's presence impact the SHIELD Project's access to factories. Some factories reportedly employ their own doctor or nurse, while others are not open to having a Thai MOPH presence. For example, concerns arise from the fact that not all factories are legally registered, and though this project does not assess the legality of factories, many owners are reluctant to invite any Thai authorities into their factories.



Mae Sot Hospital runs a taskforce on migrant health in Mae Sot and Phop Phra, Tak Province. This taskforce is organized and funded by the Thai Government and the SHIELD Project to conduct outreach and provide healthcare to migrant factory workers. This project serves approximately 13,000 persons from all ethnic groups. However, this may be an underestimate, since factory owners self-report and often exclude illegal workers from official reports. The model of service delivery for this program is to provide healthcare to Burmese migrants within existing the Thai MOPH infrastructure. The project uses migrant health workers with knowledge about public health to conduct outreach in migrant communities.

World Vision, in partnership with MAP, operated the Prevention of HIV/AIDS Among Migrant Workers in Thailand Project in migrant areas in Mae Sot (Mae Pa and Hta Silaud) and Chiang Mai until 2009. This project included RH, HIV, and STI programs. The second phase of the project began in June 2009, with a primary focus on STI/HIV prevention. Most of World Vision's work focuses on male condom distribution and STI/HIV trainings for factory,

agriculture, and construction workers. Individuals reporting STI symptoms are referred to MTC.

The International Organization for Migration (IOM) currently operates a migrant health program in Mae Hong Son, and operated a similar program in Tak, Chiang Rai, Ranong, and Phang Nga Samutsakorn from 2005 through 2009. This program worked through the Thai MOPH to deliver care for migrants but ended in 2009 due to lack of funding.

The Women’s League of Burma (WLB) serves migrant Karenni women in Chiang Mai and Hang Don districts. WLB’s organizational focus is on education about violence against women, and their reproductive health work centers on the intersection between gender-based violence and family planning issues.

Refugees

Research for this report included interviews with four stakeholder organizations working in seven of the nine refugee camps in Thailand⁸.

SMRU provides ANC, malaria treatment and prevention, and obstetric care in Mae La camp. The **IRC** provides family planning services to refugees in Ban Mai Nai Soi, Ban Mae Surin, and Tham Hin. The IRC operates health facilities in these camps and provides FP counseling, supplies, and referral services. **PPAT** operates in five camps, and offers FP counseling and supplies, clinical services, education, and referrals to Thai hospitals. **KWO** provides ARH trainings, TBA trainings, TBA kits, and maternity kits in Karen refugee camps. Three peer educators have trained 167 youth since 2005 in Mae La, Umpiem Mai, Nu Po, as well as in IDP communities in Karen State (Ah Pah Gyi and Dooplaya districts). Trainings are conducted on an annual basis as funding allows. However, lack of funding has prevented KWO from continuing these trainings as part of the Adolescent Reproductive Health Network (ARHN). KWO also oversees 42 TBA volunteers in Mae Ra Ma Luang and 38 TBAs in Mae La Oon camps in Mae Hong Son province. Though not interviewed for this needs assessment, **Première Urgence-Aide Médicale Internationale (PU-AMI)** operates clinics in Nu Po, Mae La, and Umpiem Mai.

Stakeholder organizations serving refugees

Première Urgence-Aide Médicale Internationale (PU-AMI)

Nu Po, Umpiem Mai, Mae La

American Refugee Committee (ARC)

Nu Po, Umpiem Mai, Ban Don Yang

International Rescue Committee (IRC)

Ban Mae Surin, Ban Mai Nai Soi, Tham Hin

Karen Women Organization (KWO)

Nu Po, Umpiem Mai, Mae Ra Ma Luang, Mae La Oon

Malteser International

Mae Ra Ma Luang, Mae La Oon

Planned Parenthood Association of Thailand (PPAT)

Umpiem Mai, Mae La, Mae Ra Ma Luang, Mae La Oon, Ban Mai Nai Soi

Shoklo Malaria Research Unit (SMRU)

Mae La

Coordinating CBO networks

The **Adolescent Reproductive Health Network** is a consortium of nine community-based organizations in Mae Sot that coordinate their efforts to promote sexual and reproductive health among cross-border populations and migrants age 12 through 24. Participating organizations (BMA, BWU, KWO, KYO, MTC, PWO, SAW, Tavoyan Women’s Union, and ULYO) coordinate their approach to reproductive health advocacy for adolescents and operate the Youth Center in Mae Sot, where migrants may go for counseling, group discussions, workshops, and FP supplies. The **Adolescent Reproductive Health Zone (ARHZ)** is a parallel coordinating network of CBOs in

⁸ Interviews were conducted with organizations operating in Mae Ra Ma Luang, Mae La Oon, Mae La, Umpiem Mai, Ban Mai Nai Soi, Tham Hin, and Ban Mae Surin. No interviews were conducted with RH programs operating in Nu Po or Ban Don Yang camps.

Chiang Mai (members include BWU, Lahu Women’s Organization, MAP, Nationalities Youth Forum, Pa-Oh Youth Organization, Shan Youth Power, KWAT).

The **Committee for Coordination of Services to Displaced Persons in Thailand** was formed in 1975 to coordinate communication among NGOs working in refugee camps in Thailand. Of the 17 members, eight organizations serve on the Health Sub-Committee. The Committee meets on a regular basis to share information, experience, and viewpoints among camp-based organizations [26].

ASSESSMENT FINDINGS: CROSS-BORDER POPULATIONS

Family planning

Family planning counseling

Populations living in eastern Burma have very limited access to comprehensive family planning counseling. MCH workers in facilities such as those developed by the MOM Project, the RAISE Initiative, BMA, and KDHW can provide counseling. However, according to interview respondents and FGD participants, basic information is often provided in lieu of comprehensive family planning counseling. Sites with counseling include KDHW’s 12 RH sites, BMA’s 14 RH sites, 11 former MOM sites, and six former RAISE sites, representing a total catchment population of 150,255 persons. BPHWT’s 80 teams of MCH workers are also trained to provide FP counseling.

Counseling provided by Partners/FBR in conflict-affected areas in Karen state is limited to informal and education-oriented information explaining the benefits and risks of family planning. BPHWT-trained TBAs and medics can give limited counseling, but this mostly consists of basic education about contraception and the advantages and disadvantages of various family planning methods. The outreach program run by BMA provides education to the community, but if individuals want counseling they must visit a clinic. MCH workers and trained TBAs give family planning counseling, but again, this is limited to basic education and explanation of advantages and disadvantages of FP methods.

Adolescents in particular face difficulty accessing family planning counseling. At KDHW’s 12 RH sites, MCH workers or TBAs can provide counseling, but at least one interviewee reported that this service is, in practice, only provided to married women [26]. KDHW MCH workers do clinic-based counseling, and also visit villages every six months. These workers and TBAs provide basic education about FP methods (OCPs, male condom, and hormonal injections). However, counseling is limited to educational materials about these three methods, and targets families that already have three or four children. The only organizations that report offering



ARH trainings are ULYO, KYO, BMA, KWAT, and PWO, and due to resource constraints and logistical challenges of providing cross-border trainings, it is likely that only a small number of adolescents are reached by these organizations.

Family planning supplies

It is possible for villagers in eastern Burma to buy family planning supplies in local shops, but this typically involves traveling a long distance and is often cost-prohibitive. According to one organization working in conflict-affected Lahu areas, individuals can buy supplies at a shop in a nearby town, but it is an average of three to four hours by motorbike or a half-day walk from villages. Midwives in these villages also sell contraceptives, but cost is often a barrier to access for populations living in one of the poorest regions in the country.

Because of barriers to access in IDP, rural, and conflict-affected villages, a number of organizations provide family planning supplies in clinics and also through mobile healthcare workers. The most commonly dispensed methods of contraception are male condoms, OCPs, and hormonal injections (e.g., Depo-Provera). MCH workers in the 26 facilities supported by BMA and the 80 BPHWT teams can provide male condoms, OCPs, and hormonal injections. BMA stocks cross-border facilities with female condoms, but it is not clear whether they are actually distributed. The only other organization that reports distribution of female condoms is KYO. Other organizations, including KYO, KDHW, BPHWT, and Partners/FBR distribute OCPs, male condoms, and hormonal injections at no cost. However, it should be noted that during stakeholder interviews, one organization expressed a bias in favor of distributing family planning supplies to married adults [27]. Even if this is not formal organizational policy, healthcare workers serving cross-border populations may fail to provide care—or create an environment where care is equally accessible—for unmarried adolescents.

Emergency contraception

Use of emergency contraception (EC) among cross-border populations is characterized by lack of knowledge, both among cross-border populations, and also among organizations that provide family planning services. This lack of knowledge has led to slow uptake among organizations and individuals, with few organizations serving cross-border populations dispensing the medication.

Levonorgestrel emergency contraceptive pills (ECPs) are provided in the 26 sites supported by BMA, including the former MOM Project and RAISE Initiative sites, but not by BPHWT. The most popular brand of levonorgestrel ECPs in Thailand is called “Madonna,” and is available for purchase at Thai shops for 33 baht (US\$ 1). There is no evidence that dedicated ECPs are available in eastern Burma.

Interviews with cross-border organizations indicate that at the program level, many program managers are misinformed about the safety of and eligibility requirements for ECPs. This lack of knowledge is common both among midwives and health workers who often do not know how to administer the medication. Community members, who are largely unfamiliar with ECPs, do not know how or when to ask for it.

Lack of knowledge about ECPs, in general, among HWs appears to be the greatest barrier to service delivery. However, interviewees who expressed knowledge of ECPs raised a number of questions about ECPs and expressed misinformation about EC during the interviews. The side effects of ECPs, the timeframe for use, the eligibility requirements, and the number of times in a year or a cycle that a woman can use ECPs were among the mostly common areas of confusion. When asked about ECPs’ window of efficacy to reduce unwanted pregnancy after unprotected sex, the most common response was “within 24 hours.” Lack of information has led some organizations to turn down requests for ECPs after 24 hours. For example, in Shan State, HWs report not giving out ECPs if it has been more than one day because they are not adequately informed about the efficacy of levonorgestrel ECPs in preventing pregnancy for up to 120 hours (five days) after unprotected sex.

Even where organizations dispense ECPs and have a population that is aware of its availability, a number of organizations report that it is rare for women to come forward to request pills within the 120-hour window. This is reportedly due to women’s reluctance to admit to having had unprotected sex, “shyness,” and distance. For example, KDHW stocks ECPs, but reports that no patients ask for it despite their efforts to counsel women to request ECPs when they forget to take their OCPs. KDHW reports that this lack of demand is a reflection of women being “private” about missing their OCPs. In addition to reiterating this feeling, Partners/FBR noted that

women also either underestimate their risk of pregnancy or are in denial about the risk and fail to ask for ECPs within the five-day window after unprotected sex. The challenge of dispensing ECPs within the timeframe for use is further exacerbated by the distance that many women must travel in order to reach a clinic that dispenses the medicine and the notion that ECPs should only be used in “emergencies.” The organizational interpretation of what constitutes an “emergency” influences organizational practices around ECPs.

Other communities report no access to ECPs. For example, there is no reported access to ECPs in Palaung communities in eastern Burma. PWO healthcare workers are familiar with ECPs from ARH trainings in Mae Sot, but do not offer the medication. The primary barrier they cite is the cost of ECPs and distance to nearby towns for access. However, PWO reports a higher incidence of rape in recent years and would like to start administering ECPs for these cases.

Evidence-based information: Levonorgestrel ECPs

Emergency contraceptives are medications or devices that can be used post-coitally to prevent pregnancy. Worldwide, the most common form of EC contains levonorgestrel, a type of the hormone progestin. The evidence-based protocol is the administration of 1.5mg of levonorgestrel taken in one dose within 120 hours of unprotected sex. Levonorgestrel ECPs can reduce the risk of pregnancy by up to 89%, but are more effective the sooner they are used and are most effective if used in the first 24 hours after sexual intercourse. Levonorgestrel ECPs are extremely safe—no deaths or serious complications have been causally linked to EC use—and there are no absolute contraindications. The most common side effects are nausea and vomiting and these generally resolve within 24 hours of treatment. Use of levonorgestrel ECPs may also have a short term impact on the length of the menstrual cycle and patterns of menstrual bleeding.

Levonorgestrel ECPs should be offered to any woman who has had unprotected or underprotected sex in the previous 120 hours and wants to prevent pregnancy. Women who have not used contraception (either in the context of consensual sex or in the context of sexual assault), women who have experienced contraceptive failure or accidents (such as condom breakage or slippage), and women who have incorrectly used pre-coital forms of contraception (such as missing two or more OCPs in a cycle) are all eligible for EC. Levonorgestrel ECPs do not cause an abortion and will not interfere with an established pregnancy. Levonorgestrel ECPs are not as effective at preventing pregnancy as ongoing methods of contraception (such as OCPs or Depo-Provera) and thus are not recommended for repeated use. However, there is no evidence that modest repeat use poses any significant risks and women can use levonorgestrel ECPs multiple times in a year or a cycle if needed [28,29].

For mobile health organizations like BPHWT and Partners/FBR, which operate with budget and space constraints, packing priority often goes to malaria medications and other forms of contraception over ECPs. According to Partners/FBR, ECPs are not seen as a priority when packing supplies as women do not tell medics when they have had unprotected (or underprotected) sex. However, according to Partners/FBR, if women were to identify ECPs as a priority medics would begin carrying the medication. According to Partners/FBR, dispensing ECPs will involve a great deal of education within the community as to its purpose and use. In their experience, most women will only see a medic if she perceives her health issue to be a “significant problem,” and Partners/FBR do not believe that women currently identify the risk of unplanned pregnancy as rising to this level of significance.

Family planning procedures

There appears to be virtually no access to family planning procedures among cross-border populations in eastern Burma. This includes access to long-acting reversible contraceptives (LARCs, e.g., intrauterine devices [IUDs] and hormonal implants) and male and female sterilization procedures. Although the insertion of LARCs and sterilization procedures are purportedly provided at government hospitals in Burma, many respondents voiced a lack of trust in the Burmese medical system and identified active conflict, displacement, distance, and cost as

structural barriers to accessing services. Thus referrals by cross-border organizations to Burmese hospitals are not widely used. When research was collected for this assessment none of the MCH workers in cross-border clinics were trained to perform family planning procedures. However, in December 2010 KDHW provided family planning procedural training (IUD insertion and removal, implant) to 13 MCH workers as part of a larger EmOC training.

Family planning procedures are available in Thailand in Thai hospitals. In addition, MTC provides IUDs, hormonal implants, and performs vasectomies but refers women to MSH and family planning procedures are provided in some of the NGO clinics in the refugee camps. Although there are logistic and geographic barriers, a number of organizations working close to the Thai border have developed referral systems for IUD, vasectomy, and tubal ligation services. For instance, Partners/FBR operates a referral system on a case-by-case basis to bring patients into Thailand. However, referrals to Thai hospitals are complicated by both logistic constraints and cost. In Shan State, organizations refer individuals from IDP camps along the Thai-Burma border to the hospital in Mae Hong Son (Thailand) for the full range of family planning procedures but individuals bear the cost, which are generally prohibitive.

Context: Perspectives on vasectomies

The men don't like the idea of vasectomy because they think they cannot make a baby anymore so the husband will not be loyal to their wife, or they think they cannot enjoy sex...Some women think if they do tubal ligation they cannot work in hard labor in the field anymore. (Interview, Mae Sot, August 19, 2010)

One man drank two beers before he went to get a vasectomy because he was shy to have it done. He says after the vasectomy his relationship improved with his wife because she allows him to sleep with her now. Before, she was always afraid of pregnancy so she made him sleep in the other room with the children. Some worry the semen will not come out. But this man confirmed that sex is the same after. (Interview, Mae Sot, August 9, 2010)

As a result of the overall context and the structural barriers to accessing service, a number of stakeholder organizations expressed concerns about the “appropriateness” of LARC use among cross-border populations. BMA clinics in particular appear especially concerned that IUD maintenance (and specifically the requirement that women manually perform “string checks”) could be compromised by unhygienic conditions and practices. Further, a number of organizations feared that security risks might prevent IDP women and women living in conflict-affected areas from having their IUDs removed in sterile settings.

Evidence-based information: Male sterilization (vasectomy)

Male sterilization is a highly effective and safe method of permanent contraception and may be appropriate for individuals or couples who have decided they do not want to have children or do not want to have additional children.

A vasectomy is a surgical procedure in which the vas deferens is cut and then sutured closed thereby preventing sperm from being expelled through the penis during ejaculation. Male sterilization is more than 99% effective at preventing pregnancy, although men are advised to use a back-up method of contraception until there has been confirmation that there is no longer sperm in the ejaculate (typically six to twelve weeks after the procedure). The procedure is extremely safe and complications are rare. Discomfort or pain associated with the procedure is usually relieved with paracetamol and typically resolves within days of the procedure. After the procedure men are advised to rest for two to three days and to avoid heavy lifting and strenuous activity for five to seven days. Having a vasectomy does not affect testosterone levels, sex drive, or the ability to have an erection and men can resume sexual activity one week after the procedure. Vasectomies are not associated with increased risk of cancer or cardiovascular disease. Male sterilization does not prevent the transmission of HIV or other STIs [30].

Finally, there appears to be an overall lack of awareness about LARCs and sterilization procedures at the community level. For example, KDHW does not currently have a referral system in place for family planning services because of lack of community awareness about the availability of these procedures. There also appears to be significant misinformation about LARCs and sterilization procedures among both health providers and the broader community.

Common barriers to family planning access among cross-border populations

Cross-border respondents report distance, lack of funds, and general mistrust of the hospitals in Burma as barriers to accessing family planning counseling, supplies, and procedures. Other barriers noted by organizations and FGD participants included the lack of consistent and reliable family planning supplies, a dearth of trained healthcare workers, a widespread lack of information and education about reproductive health, pervasive misperceptions about contraceptives and FP methods, a lack of support from cross-border community leaders, socio-demographic disparities based on age, marital status, or gender, the primacy placed on large family size as a result of ethnic conflict, and the overall public health situation in eastern Burma.



Resource constraints, and specifically disruptions in family planning supplies and a shortage of trained providers, were repeatedly identified as a major barrier to contraceptive access. In particular, organizations noted that unmet need for OCPs and Depo-Provera was considerable. Further, a number of organizations identified the turnover of health workers as a significant challenge to building capacity in family planning service delivery. In Karen State Partners/FBR is developing a new model for medic training by opening a school that will house and train a limited number of medics for a full year. Other issues voiced by interviewees include the occurrence of trainings on the Thai side of the border that do not always translate into the context of cross-border service delivery. However, BMA, KDHW, the MOM Project, and other organizations tailor trainings specifically to work in conflict areas. In addition, most of these trainings are training of trainers, so participants that attend return to their communities and conduct additional trainings with other health workers and TBAs in eastern Burma. Furthermore, as discussed above, there is a dearth of healthcare workers trained in family planning procedures, including IUD insertion and removal.

Security and safety risks limit the movement of both health service providers and populations living in eastern

Burma. Access to family planning supplies and services is compromised by the distances that villagers must travel in order to purchase supplies; sometimes up to a full-day walk or half-day motorbike drive to a shop with supplies in stock. In addition, serious threats to safety, including landmines and risk of attack by the SPDC, restricts the movement of cross-border medics, trainers, and medical supplies. Security risks exacerbate logistical challenges that already limit what mobile teams can carry with them into IDP and conflict-affected areas and confiscation of supplies is a real concern.

From heightened concern about side effects and rare complications, to medically inaccurate beliefs about the long-term consequences of contraceptive use, **misinformation** within cross-border populations regarding family planning methods is widespread. Misinformation about family planning appeared to have impeded uptake of both individual contraceptive methods (such as OCPs and IUDs) as well as contraception in general. Men reported having heard in the community that after having a vasectomy a man will be unable to work or lift heavy items and may lose his ability to have sexual intercourse. However, according to one stakeholder, men from cross-border populations are more open to vasectomy than migrant and refugee populations, likely due to the challenges faced by men and women who need to repeatedly go to a clinic for ongoing supplies of contraception.

Beyond the issue of misinformation, among cross-border populations there is **stigma** associated with certain contraceptive methods (particularly LARCs and sterilization). However, according to one cross-border organization, this tends to be less of an issue in cross-border communities than among migrant and refugee populations at least, in part, because structural barriers make accessing health workers and other forms of contraception difficult. According to this individual, practical constraints on movement and access to family planning resources has created to more openness toward LARCs and sterilization. Stakeholder organizations almost universally reported low condom use among cross-border populations. Challenges to increasing use of condoms include power dynamics and male perceptions that wearing condoms is like “taking a bath with your clothes on” [31].



Organizations report that in some cross-border communities, **lack of support among community leaders** is a challenge to delivering family planning services in eastern Burma. In particular, Karen leaders are reportedly hesitant to agree to community education about reproductive health, in general, and family planning, in particular. In order to address this issue, one organization has started to facilitate discussions between community leaders

and CHVs, medics, and TBAs prior to introducing community-wide education or trainings. In addition, religious leaders in cross-border communities, particularly those in Catholic communities, often serve as a barrier to information and community-wide education. Based on the experience of the MOM Project, gaining support of community leaders can be a challenge, but one that can be overcome. For example, while some Karen leaders were initially hesitant to participate in the MOM Project, over time many village heads and religious leaders joined vocal community advocates to lend support to the project.

Age, marital status, and gender are widely reported as a barrier to family planning access. Although there is an overall lack of reproductive health education and family planning information within cross-border populations, this is even more pronounced among adolescents. Unmarried people have more limited access to family planning in cross-border settings than in migrant areas in Thailand due to lack of anonymity, stronger cultural resistance, and health worker biases. Organizations working with cross-border populations do not universally provide information, services, and supplies to unmarried persons because of the perception that unmarried people do not need family planning. The notion that unmarried people do not need family planning is furthered by the practice of forced marriage in the case of out-of-wedlock pregnancy. Furthermore, even for married couples, at least one organization reported preference for outreach strategies focused on married couples with three or more children over married couples with less than three children.

Context: Age, marital status, and gender as barriers to family planning access

Adolescents can come to clinic, but the barrier is from the community. They are shy to come because the people will look down on them...For single males it's a little easier to access family planning because they have more rights than females. (Interview, Mae Sot, August 2, 2010)

If they are not married, they cannot take contraceptives. (Interview, Chiang Mai, August 18, 2010)

Unmarried people can access contraception from select health educators and health workers, or purchase condoms and OCPs in local shops. However, as discussed above, travel within eastern Burma is challenging, expensive, and dangerous. In addition, young people are reportedly “shy” and apprehensive about procuring reproductive health information and family planning services. ARH trainings for cross-border adolescents are offered by ULYO, KYO, KWO, BMA, PWO, KWAT, Lahu Women Organization, and BWU, but security and resource challenges limit the number of adolescents reached. KDHW offers trainings only for married women and BPHWT does not conduct ARH trainings.

In addition to age and marital status, gender often serves as a barrier to care among cross-border communities. FGD participants and cross-border stakeholder organizations identified reproductive health and family planning as the responsibility of women. According to one cross-border organization, women's health is often regarded as a low priority issue, which influences when women seek care. Further, stakeholder organizations and FGD participants identified gender roles as an important aspect in whether women can access family planning services. Numerous respondents reported that if a man does not want his wife to use family planning, she cannot seek out counseling or supplies. Organizations noted the need to include more men in family planning counseling sessions to increase awareness about contraception and the benefits of birth spacing. The MOM Project has integrated male involvement into its strategy, teaching HWs about the importance of engaging men in family planning conversations, and practicing this strategy via role play.

Maternal mortality

Direct and indirect causes of maternal death and associated factors

Because of the region's isolation, the dangers of delivering care in conflict-affected regions, and logistical challenges inherent to the eastern Burma context, maternal mortality ratios in eastern Burma dwarf the MMRs

in both Thailand and Burma as a whole. Lack of access to skilled birth attendants, lack of knowledge about emergency obstetric care among local TBAs, and lack of access to safe abortion have a considerable impact on maternal mortality in the cross-border context.

Postpartum hemorrhage (PPH) and unsafe abortion are the most commonly reported causes of maternal death and injury for cross-border populations. BPHWT reports that 37% of maternal deaths are caused by PPH [20]. BPHWT estimates that other causes of maternal mortality within the cross border population are malaria-induced fever (18.75%), prolonged or obstructed labor (12.5%), and pre-eclampsia (12.5%). Complications secondary to retained placenta, malnutrition, and unsafe abortion are other significant contributors to maternal death in eastern Burma.

Cross-border organizations emphasized the link between a lack of access to family planning and high rates of maternal death, noting that women who have had multiple children are at higher risk of PPH. Furthermore, organizations emphasized the role of nutrition, noting that many pregnant women are anemic, so the loss of even a small amount of blood can have a profound impact. Other chronic health issues affecting maternal mortality include hookworm and chronic malaria.

Context: Perspectives on maternal mortality

Everyone you talk to knows someone who's died as a result of lack of access to care, but there's a perception that you shouldn't seek it out—and when they do it's often too late. (Interview, Chiang Mai, October 23, 2010)

One woman in our Karen village had obstructed labor and could not deliver. The TBA pushed and then two men used bamboo. They laid it across her stomach and pushed down on her stomach to try to push the baby down. The baby did not deliver and the woman died. (FGD, Mae Sot, October 21, 2010)

Stakeholders estimate that travel to the nearest facility ranges from a one-hour walk to a multiple day journey for many women living in eastern Burma [32]. Often the closest facility has no personnel trained in delivery care, let alone EmOC. A number of organizations have been trying to address these challenges. The MOM Project engaged with ethnic health departments and BMA to train medics in EmOC and create a network of mobile, trained medics and TBAs to work within communities to increase access to skilled birth attendants in eastern Burma. BMA supports 18 sites that have health workers trained in EmOC through the MOM Project and RAISE. The MOM Project supports three levels of health workers: trained TBAs (without EmOC skills), reproductive HWs with limited EmOC skills, and reproductive HWs with EmOC skills [14].

BPHWT has run a MCH Program since 2000. By conducting annual trainings with TBAs, BPHWT aims to train ten TBAs for every 2,000 people in their service area. To date, BPHWT has trained 742 TBAs and BPHWT-trained TBAs have assisted in 3,708 deliveries. BPHWT has also organized the distribution of maternity kits to pregnant women since 2006. Partners/FBR conducts medic trainings on EmOC in Karen State, and is currently adopting a one-year in-residence medic training model.

Stakeholder organizations report there have been some limited gains over the last decade. For example, BPHWT notes that an increase in referrals to MTC and increased uptake of family planning among cross-border populations has resulted in an overall longer-term trend of reductions in maternal death. However, BPHWT reported 16 maternal deaths in 2009, which represented an increase from 2008 [20]. Between January and August of 2010, there had been two maternal deaths reported in areas where EmOC services are provided [33]. Numerous cross-border organizations have also noted increased availability—from agencies in both Thailand and Burma—of medications to prevent and treat PPH, including oxytocin, misoprostol, and ergometrine.

Challenges to reducing maternal mortality in eastern Burma

Context: Perspectives on the challenges to reducing maternal mortality in eastern Burma

In Shan State they use TBAs but they have no training, so they don't use sterile methods. They have unsafe deliveries because they don't have training. They have no supplies and no knowledge. The Burmese government doesn't care about the ordinary people. (Interview, August 19, 2010)

Women's health is often regarded as a last priority issue. Most women don't go to medics unless it's a significant problem. Their children go, but the women put themselves as a low priority. (Interview, October 23, 2010)

Structural barriers to reducing maternal mortality in eastern Burma, including the **distance villagers must travel to reach health centers or access a skilled birth attendant and security risks**, were widely reported. Government hospitals in Burma are too far for most villagers to reach, particularly in an emergency, and most are reportedly ill-equipped and cost-prohibitive. For example, KDHW reports that there is no place to refer for a cesarean section in its target region. In an emergency, KDHW will refer to a government hospital in Burma and pay the transportation costs, but the patient will have to pay



for the cost of medical care on her own. Of course, there are risks and logistical challenges involved with moving throughout the region, particularly in conflict areas.

A number of organizations refer women to services in Thailand (e.g., MTC, Thai MOPH hospitals). For example, in Shan State SHC refers pre-eclampsia cases to the Thai hospital in Mae Hong Son. However, there are pronounced logistical challenges—before referring a patient to a facility in Thailand, the organization must inform the Thai military, and only if the case is sufficiently serious will the military permit the transfer. Transportation costs can be prohibitively expensive (often in the US \$50 to \$66 range for a 1.5 hour trip) and if security needs to be provided during the transfer process, the total costs associated with the delivery are substantially higher. These dynamics were a major factor in the development of the MOM Project's three-tiered community based approach.

Organizations working in eastern Burma reported **lack of supplies and lack of medic training** as key challenges to improving maternal mortality in the region. Organizations that engage in EmOC trainings face the challenge of medic turnover. As discussed in the family planning section, the high rate of medic turnover in eastern Burma hinders the ability of organizations to do in-depth EmOC trainings. According to one organization, this turnover is a result of security, displacement, and movement of the medic population within the region, as well as a popular belief that a little education is better than nothing. The constant influx of new trainees means that experienced medics often repeat introductory trainings and organizations do not always get the opportunity to facilitate follow-up trainings or introduce new or more advanced topics.

According to stakeholder organizations, **communication between untrained TBAs and medics is poor**, exacerbating the already-poor access that women have to skilled birth attendants. In Karen State, organizations report that

untrained TBAs will only call the medic if the situation is a dire emergency. In Lahu villages, stakeholders report that Lahu TBAs are often trusted more than the Burmese trained (skilled) midwives, and women commonly seek care from TBAs over HWs with EmOC training. Organizations report that in order to reduce maternal death, effort must be taken to build trust between the two groups in order to improve communication and encourage TBAs to contact medics for assistance in the early stages of a complication. The MOM Project has implemented this model, whereby TBAs and reproductive HWs are trained to work together and build teams. Notably, the RAISE Initiative has not included this component. Rather, the RAISE Initiative focuses on facility-based EmOC training, without the integration of TBAs.

Unsafe abortion

Prevalence

There are mixed reports of abortion prevalence in Burma. Several program managers insisted that abortion does not happen in areas where they work, while others that work in the same areas told stories of women who induced abortion using a variety of unsafe methods. Furthermore, there is a perception that induced abortion only happens in “the border area,” or in migrant communities, and not in ethnic villages in Burma. Some interviewees claim that induced abortion does not occur in certain areas (for example, the Christian Karen area) because of community religious beliefs and only recognize the occurrence of spontaneous abortions. However, other organizations and individuals interviewed for this assessment report that unsafe abortion is prevalent throughout the cross-border region.

Interviewees and FGD participants reported a range of abortion practices in the Thai-Burma border region. Commonly used methods include abdominal massage, consumption of malaria medications, “traditional” medicines, and the insertion of a stick or other instrument into the vagina. Abortions are most often performed by TBAs, and associated health risks noted by organizations and FGD participants include incomplete abortion, infection, fever, bleeding, pain, weakness, and death.

Organizations often related the issue of unsafe abortion to a lack of access to family planning. Stakeholder organizations and FGD participants noted that pregnancy termination is used most often by young unmarried women and women who have already had multiple children or pregnancies, and almost always when family planning methods were not available. One nurse interviewed for this assessment reported that it is not uncommon to encounter women who have had up to five or six terminations using unsafe methods. The most common practice she sees is the insertion of a package of herbs into the vagina, the result of which is an infection that terminates the pregnancy.

Context: Perspectives on abortion practices in the Thai-Burma border region

They put a stick with a mirror on it inside the uterus and use a needle.

Massage to destroy the fetus.

Traditional medicine, Kay Thi Pan, mix yellow powder with honey and drink, TBAs massage the uterus, drink young coconut water.

Drink traditional medicine from root of a tree.

Some take medicines like Kay Thi Pan, quitizaine (traditional Burmese medicine), or antimalarial drugs.

Some women go to the woman who will do the abortion illegally. She will push on the belly and massage the uterus.

Some people jump and do strenuous activity.

Some people slip and fall down, some carry heavy things.

There are different plants to put inside the uterus. We can get them from a market in Burma. There is a traditional tablet made with a traditional leaf, plants, and tree. They put it inside themselves.

If the income is not enough, sometimes the husband doesn't want the baby, so he kicks his wife.

Leaf spine, spine of papaya leaves, stick, straw, some people use iron slices, hot massage, the kind of plant when you touch it it's itchy. The leaves look like a lily.

In Kayah area they use a big fishing hook and put it inside the uterus.

Legal risks

Abortion is illegal in Burma except to preserve the woman's life and is legally restricted in Thailand. However, cross-border populations do not perceive legal risks of induced abortion to be from Burmese or Thai authorities, but from the local community. For example, interviewees and FGD participants note that the Karen National Union will punish a woman in Karen State with detainment if she is caught terminating a pregnancy. In one community, it appears that single women are fined by community leaders for terminating a pregnancy. However, there appears to be a wide range of enforcement at the community level.

Community attitudes

Virtually all respondents reported community disapproval of induced abortion, particularly among community leaders in civil and religious spheres. According to one respondent, "the old people blame the woman because they say she killed the baby. The religious leaders will say she killed the baby" [34]. According to another respondent, "If the woman has psychosis, people will understand if she wants an abortion, but for the normal woman, the community will criticize and look down on her" [35]. Women in some cross-border communities are expected to apologize to local leaders, including Buddhist community leaders, for having terminated a pregnancy.



In one community, if a woman is single, the community will reportedly ask her to pay a fine [36]. In addition, unmarried women who are found to be pregnant or who attempt to terminate a pregnancy have been reportedly forced marry the father, even if the pregnancy was the result of rape [36].

Access to safe(r) abortion

There is virtually no access to safe and legal abortion in Burma and respondents had limited knowledge of safe(r) options for abortion care. In addition to the practices listed above, some respondents indicated that there are women in some cross-border areas using misoprostol to induce an abortion. There were somewhat conflicting reports about the availability of misoprostol along the border: MTC reported that misoprostol can be purchased in Myawaddy whereas Partners/FBR reported that it is widely available on the Burma-India border, but less so along the Thailand-Burma border. Other cross-border organizations report the presence of mobile, unlicensed, and untrained "pharmacists" that sell misoprostol in villages in eastern Burma.

A number of organizations voiced concerns about the availability of misoprostol in the region. Most organizations that currently administer misoprostol limit its usage to the prevention and treatment of PPH. In addition to PPH prevention and treatment, BMA uses misoprostol for the management of incomplete abortions and MTC uses misoprostol for a range of indications, including PAC and incomplete abortion management, induction of labor at full term, and treatment of cases of intra-uterine fetal demise. No organizations servicing cross-border populations reported provision of misoprostol specifically for early pregnancy termination. Thus it is likely that when misoprostol is used to induce abortion, it is through self-induction. Respondents expressed concern that the lack of knowledge among cross-border populations about basic reproductive physiology (such as the menstrual cycle) coupled with menstrual irregularities secondary to malnutrition make gestational age difficult for women

to accurately estimate, and respondents cited concern about women using misoprostol too late. For instance, one cross-border organization reported that “a number” of cases of fetal anomalies or severely disabled babies could be attributed to in utero exposure to misoprostol (secondary to a failed attempt to use misoprostol to induce an abortion during the second or third trimester).

ASSESSMENT FINDINGS: MIGRANTS

Family Planning

Family Planning Counseling

There is very little access to comprehensive family planning counseling in migrant communities. Common routes of disseminating information include peer education, workshops, and individual or group discussions. FGD participants report that most migrant workers talk to their friends to learn about family planning, a dynamic that was confirmed by one organization working with migrant communities.

In addition to learning from peers, some migrants attend trainings and workshops provided by individual NGOs or CBOs (MAP, World Vision, IRC, SAW) or may participate in group discussions, workshops, and counseling at the ARHN Youth Center in Mae Sot, which serves approximately 100 clients per month. BWU holds monthly group discussions for 20-30 migrants, but family planning is only one of many topics covered in these discussions. Other organizations conduct outreach in migrant communities through peer educators or health outposts (SAW, SHIELD), while others visit factories (BWU, SAW, World Vision), or operate libraries and drop-in centers (BWU, SAW, World Vision, MAP, KWAT, ARHN Youth Center). For example, the SHIELD Project operates factory-based health outposts that provide family planning counseling, supplies, and home visits via migrant health workers. In addition to group discussions, BWU’s drop-in center provides counseling. However, in general, services focus on general education rather than individualized counseling. FGD participants most commonly identified the ARHN Youth Center and MTC as places to access family planning counseling.

Evidence-based information: Family planning counseling

Counseling is a critical component of family planning service delivery. Family planning counseling includes the provision of medically-accurate, non-biased information about a full range of available contraceptive methods and a supportive environment in which the client can explore and articulate her or his individual needs, preferences, priorities, and questions. This empowers individuals to make an informed choice about the use of contraception and the selection of a contraceptive method that is most appropriate for their individual circumstances. High quality family counseling helps to ensure the correct use of and satisfaction with the chosen method. Family planning counseling should be provided to all individuals regardless of age or marital status. Clients should have a range of methods to choose from and should be able to choose from all methods for which they are medically eligible [37].

Resource constraints were cited by organizations as a key reason for not offering family planning counseling. For example, one organization noted that financial and human resource constraints limit their counseling services to basic education about contraceptive methods. Further, family planning counseling may be offered in Thai clinics in migrant areas, but because of structural, financial, cultural, and linguistic barriers, migrant workers typically do not visit these clinics for counseling or supplies.

Family Planning Supplies

Migrant access to family planning supplies is limited. Migrant areas with the greatest access to contraception have health educators and other outreach programs within their communities (MAP, World Vision IRC, SAW, and BWU). Drop-in centers and MTC are also important sources of contraception, but access is heavily influenced by distance.

The most commonly available forms of contraception are OCPs and male condoms. Stakeholder organizations and FGD participants report that hormonal injections and OCPs are the most popular forms of contraception among migrant communities. Hormonal injections are available through Thai MOPH health centers (e.g. MSH), private clinics, MTC, IRC, limited factory-based health outposts, and the ARHN Youth Center in Hua Fai. Female condoms are also available through MAP, MTC, BWU, SAW, and the ARHN Youth Center in Hua Fai. However, organizations report that female condoms are not commonly used. All organizations (except MOPH facilities and private clinics) that provide family planning supplies to migrants report to do so at no cost.

Though Thai hospitals and sub-district health centers (animai) offer family planning supplies, there is much trepidation within the migrant community about accessing supplies through Thai facilities, and distance, security checkpoints, and cost are all barriers. For example, if a migrant worker does not have an identity card and is therefore ineligible for the 30Bt (\$1.00 USD) co-pay, he or she will be asked to pay for services. It is unclear whether facilities will provide FP if an unregistered individual says she cannot pay, and this may depend on the individual nurse or health worker rather than

on an overall policy. Nonetheless, fear of being asked to pay out-of-pocket for services prevents many migrants from attempting to access FP from these facilities. Furthermore, Tin Tad Clinic reported that although migrants may access supplies through Thai public hospitals or private clinics, lack of counseling and information about the chosen method and potential side effects may impede correct use. Stakeholder organizations noted that because of challenges accessing Thai clinics, most migrants will only visit these facilities for urgent needs.

SHIELD outposts in Phop Phra will soon no longer carry family planning supplies and thus migrant workers in this catchment area will be required to travel to the Thai sub-district health centers. As discussed above, the SHIELD Project works with the Thai MOPH to build relationships between the sub-district health centers and the migrant community, but structural barriers to access persist, both for migrants, and also in terms of resource constraints for MOPH outposts and the prioritization of FP supplies within Thai Provincial Health Offices.

Emergency contraception

There is very little knowledge about ECPs in the migrant community and among healthcare providers that serve migrants. While this lack of knowledge is reported as the most common barrier to ECP access and use, one organization reportedly stopped offering ECPs based on the perception that women were using ECPs “too often.” Thai sub-district health centers do not provide ECPs, but migrants can buy ECPs in local Thai shops. Free ECPs are available at MTC, the ARHN Youth Center, the BWU drop-in center, and MAP, but these organizations report low levels of use. For example, MTC sees approximately five women a month who ask for ECPs typically after forgetting to take their OCPs, experiencing condom failure, or failing to use another contraceptive method. Most organizations claim that this is due to lack of knowledge about ECPs in the community. ECPs are only available at MSH in cases of rape (of which there are approximately five cases per month) and not for other reasons.

Family Planning Procedures

IUDs and implants are available at Thai public hospitals, but are only free for those migrants with work permits or identity cards after paying the 30Bt registration fee. Lack of funding and trained personnel prevent the Thai sub-district health centers from providing IUDs. MTC and SMRU provide IUDs and implants for free at their clinics in migrant areas.

Context: Cost of contraception in Thailand

Most FGD participants did not know the cost of buying condoms, OCPs, ECPs, or hormonal injections in local shops and health centers. The following list presents the typical retail price of common contraceptive method:

Male condoms: US\$0.33 each, US\$0.66 per three-pack
OCPs: US\$0.66-US\$1.00 per cycle
Hormonal injection: US\$0.66-US\$1.00 per injection
ECPs: US\$1.00 to US\$1.50 per dose

Some organizations expressed apprehension about the use of implants and IUDs among migrant women based on concerns that women would remove their IUDs outside sterile settings. Migrant women’s living conditions are often perceived as unhygienic and stakeholder organizations appeared concerned about IUD insertion and removal, in general, as opposed to “self-care” requirements, which were poorly understood or defined. There appears to be cultural resistance within the migrant community to IUD use because women are “shy” and therefore reluctant to undergo the insertion procedure. A number of organizations also noted the expense of offering implants and IUDs as a challenge to offering this form of contraception. According to one organization, the cost of an IUD is US\$80, which is likely an overestimate. Misinformation about the risks and complications associated with IUD use was pervasive.

Evidence-based information: The IUD

The IUD is a safe, effective, long-acting reversible method of contraception. The IUD is a small plastic device (often shaped like a T) that is inserted into the woman’s uterus through the cervix by a trained clinician. The IUD is over 99% effective at preventing pregnancy and, depending on the type of IUD, it can remain in the woman’s body for 5-10 years. However, the woman can choose to have a clinician remove the device at any time.

Insertion of the IUD is generally very safe and women may experience moderate cramping and some spotting after the procedure. This typically resolves within a week. A small percentage of women (2%-8%) may expel their IUD in the first year after insertion. If the IUD is expelled, the woman should use a back-up method of contraception and return to the clinician as soon as possible. Although rare, about 1 in 1,000 women will experience complications (such as uterine perforation or infection) during the insertion process and will need further treatment.

Two thin plastic strings are attached to the end of the IUD. Once inserted, the clinician will cut the strings of the IUD so 1-2 inches hang out of the cervix into the vagina. In order to confirm that the IUD remains in place and is not expelled from the uterus, women are asked to feel for the strings once a month. This “string check” is a simple process that involves inserting the finger into the vagina. Women throughout the developing world and in low resource environments use IUDs and there are no special self-care requirements that would prohibit cross-border, migrant, or refugee women from utilizing IUDs.

Most women who are sexually active and want to prevent pregnancy are eligible for IUDs. However, there are some women who should not use IUDs, including women who have certain types of cancer, a current STI, a current or recent history of pelvic inflammatory disease, abnormal vaginal bleeding, certain liver diseases, or an allergy to any part of the IUD. However, women who are unmarried (including adolescents), have never had children, or have had many children and are otherwise medically-eligible can use IUDs [38].

Male and female sterilization procedures are available at Thai hospitals, and these procedures are free for those with identity cards. SMRU provides these services at their clinics as well and report that women rarely seek sterilization services at Thai hospitals. MTC performs vasectomies but refers women to MSH for tubal ligation. Most other organizations (BWU, SAW, MAP) refer clients to MTC for IUDs or implants, and either to MTC for a MSH referral or directly to MSH, for tubal ligations.

Most organizations report that very few men request vasectomies. Similar to other communities, misinformation regarding sterilization procedures is pervasive throughout the migrant community. Migrant men do not seek out vasectomies because of the perception that they will lose physical strength, sex drive, or their penis. FGD participants also report concern in the community that getting a vasectomy will signal that they are unfaithful. Organizations and FGD participants report that women also shy away from sterilization procedures. For example, the Tin Tad Clinic reported that they have never had a female client ask for tubal ligation. However, for organizations that reported cases of tubal ligation, it is most often carried out in a hospital after delivery. One organization noted that language barriers present a particular challenge for migrants seeking services at Thai

hospitals and there have been cases in which sterilization procedures have been performed on women who have not provided informed consent.

Context: Perspective on the acceptability of sterilization

We have never seen a man ask for a vasectomy. They think they cannot carry heavy things after they do this. Women do not need to worry about this because their work is not so difficult to carry things. (Interview, Mae Sot, August 3, 2010)

Common barriers to family planning access among migrants

Both stakeholder organizations and FGD participants reported **resource constraints** as a major barrier to family planning counseling, service delivery, and contraceptive utilization. Further, there appears to be a discrepancy between what the migrant community perceives is needed and the Thai MOPH approach to family planning in migrant areas. FGD participants repeatedly expressed concern that as family planning supplies disappeared from health outposts they would be left with no access to affordable contraception. However, the Thai MOPH would ultimately like the migrant community to obtain all family planning methods from the Thai health centers and MOPH-supported outposts. Thus there is an apparent disconnect between community perceptions that view Thai MOPH services as inaccessible and the Thai MOPH strategy which seeks to increase migrant access to care.



Security, distance to health centers and clinics, and lack of work permits were repeatedly cited as structural barriers to contraceptive access and FGD participants were nearly unanimous in citing security as the most significant obstacle to obtaining contraceptive services. Traveling even a relatively short distance to shops, drop-in centers, and clinics can be a tremendous challenge for undocumented migrants. Security checkpoints and traffic officers that demand bribes not only instill fear of arrest and deportation into migrants seeking healthcare, but the lack of funds to cover the additional expenses makes travel even more challenging. Further, unless

organizations are working directly in a migrant’s particular community, the individual must find the time (and resources) to travel to a clinic or provider. These distances can be considerable and combined with the costs and threats to security, pose a significant barrier. The SHIELD Project is working to address this issue by developing the Community Health Volunteer program in 140 sites in Mae Sot and 56 sites in Phop Phra. This program provides migrants with the opportunity to see a CHV in the evenings, and removes security risks created by regional travel. However, because of resource constraints, CHVs will soon only supply reproductive health education, as family planning supplies will no longer be stocked at these outposts.

Misinformation about family planning supplies and procedures is pervasive in the migrant community and serves as a barrier to access. FGD participants often expressed that fear over the side effects of various contraceptive methods, including OCP and injections, was a key reason for non-use. This dynamic was characterized by both heightened concern about documented side effects and rare complications (e.g., concerns about weight loss/gain after OCP uptake) and concern about complications for which there is no medical evidence (e.g., infertility as a result of OCP use). Further, as voiced in the FGDs, men do not like using condoms, which are characterized as “uncomfortable” and “hot” and organizations have expressed a desire to increase trainings on condom use to improve community acceptance of male condoms for family planning. With regard to family planning procedures, there is considerable misinformation associated with both sterilization and LARCs. Vasectomy is widely thought of as a procedure that precludes men from working, carrying heavy things, and engaging in intercourse. FGD participants also voiced the belief that because the “tubes were tied” in tubal ligation and vasectomy, women were at risk of pregnancy if and when the “tubes became untied.” Lack of information about reproductive health, in general, and family planning, in particular, is even more pronounced among young people, many of whom were not able to name any family planning methods.

Age, marital status, and gender also impact individual migrants’ access to family planning resources. Organizations report that even if services are available to unmarried persons and adolescents, the majority of their clients are married. This reflects the common perception that unmarried or young people do not need family planning supplies or counseling or that they are too “shy” or embarrassed to seek out information and supplies. Both organizations and FGD participants reported that many women were reluctant to take OCPs in migrant communities because of the close living quarters and fear that neighbors would know that they were taking contraceptives. MTC reported few unmarried family planning clients and attributed this to both shyness and the misperception that family planning services are only available to married persons. MTC reports that young and unmarried people will instead access supplies in the shops—without instruction or information—and therefore risk misuse of their chosen method.

Organizations report that even if their services are open to both men and women, it is mostly women that access their services. This may reflect the perception that family planning falls under the purview of women and is not the responsibility of men. Indeed, in the FGDs, men often expressed the belief that the responsibility for pregnancy prevention lay solely with women. However, FGD participants and stakeholder organizations also reported that young and unmarried men are more likely than their female partners to request OCPs or condoms at shops and from health educators. Thus there seem to be complicated dynamics with respect to what “responsibility” for contraception entails.

Context: Barriers to family planning access

Both married and single people don’t know about family planning, but single people are more afraid people will gossip about them. (Focus group discussion, Chiang Mai, November 10, 2010)

Finally, the **cultural concept of “shyness”** appears to have a tremendous impact on migrant women’s contraceptive decision-making and use of services. This concept transcends age and marital status. According to numerous organizations, women (in general) are hesitant to adopt family planning methods that involve vaginal self-contact

(e.g., female condoms, IUDs) or a clinical vaginal examination (e.g., IUDs) because of “shyness.” “Shyness” was also repeatedly cited as a reason why women did not seek services even when they were available and as a barrier to disseminating information about family planning, reproductive health, and reproductive anatomy.

Maternal mortality

Direct and indirect causes of maternal death and associated factors

PPH, induced abortion, and malaria are reported as the most common direct and indirect causes of maternal mortality among migrants. Migrants who deliver at home usually do so with a TBA, and access to skilled birth attendants is available at Thai hospitals, MTC, or one of three SMRU migrant clinics.

Women who need EmOC services reportedly face significant challenges overcoming structural barriers, including security, language, and financial constraints. For example, in Fang district, migrants must travel an average of 45 minutes by truck to access EmOC, and access to care depends on whether they have an identity card. For migrants without such documentation, a cesarean section is approximately US\$300 to US\$500 in a Thai hospital, and individuals will incur debt for whatever amount they are not able to pay at that time. For migrants with an identity card, services at Thai MOPH hospitals are free after payment of the registration fee. One organization reported that these structural barriers may cause migrant women to return to Burma for care. According to WLB, Karenni migrants who are afraid of Thai hospitals because of the language barrier and their lack of documentation will sometimes return to Burma to deliver. Women in Phop Phra face greater barriers to accessing skilled birth attendants than women in Mae Sot and often deliver at home. In this region, migrant women must pass multiple checkpoints and pay a significant sum to get to MTC or MSH.

Stories of maternal death secondary to a lack of access to EmOC are rare within the migrant communities. However, MTC sees approximately four to five maternal deaths each year, usually from PPH, heart failure, and sepsis from induced abortion. Other organizations and individuals related stories of maternal death among migrant women from unsafe induced abortion, although these deaths are likely underreported.

Unsafe abortion

Prevalence

Given community attitudes and the legal status of abortion in Thailand, abortion prevalence in the migrant community is hard to estimate. However, organizations and individuals in the migrant community report that unsafe induced abortion is widespread. According to organizational interviews and FGD participants, induced abortion is most often performed by untrained TBAs, family members, or by women themselves.

Context: Perspectives on unsafe abortion in the Thai-Burma border region

We know one woman very well; she used to come here very often. She did it by herself and when she had complications she called us, but it was too late. She went to Myawaddy to the traditional healer. She smelled very bad. She worked in the factory and had a boyfriend. She didn't tell anyone, and her boyfriend didn't let her tell us until it was too late. She was 20 years old. This happened in February 2010. (Interview, Mae Sot, August 3, 2010)

I received an induced abortion two year ago. I nearly died. A woman put a stick in my uterus and afterwards I got a fever and infection. I went to MTC for treatment and received a Depo. About one and a half months after the abortion, I had bleeding and spotting. I still have discharge and itching even now. I feel bad and have itching and pain my uterus. (Focus group discussion, Mae Sot, October 16, 2010)

After an unsafe abortion there is bleeding and some have a boil in their womb, so they have to operate and take out their womb. Some of them die. Especially the very young ones. They bleed everywhere, even their nose, their ears, and their mouth. (Interview, Mae Sot, August 8, 2010)

In 2009, 15% of MTC's obstetric admissions were for PAC. MTC reports that most PAC patients are aged 20 to 30, and already have children. The risks of unsafe abortion reported by MTC include infection, hemorrhage, perforation, bleeding, and death. SMRU notes seeing the same amount of abortion (spontaneous and induced) in migrant clinics as in refugee clinics. MSH reports an average of 2-5 maternal deaths from abortion each year. In Chiang Mai, one respondent reported that migrant women often return to Burma to induce abortion.

Tin Tad Clinic stated that they have never seen a case of induced abortion, noting that since abortion is restricted in Thailand, women who have had induced abortions may be reluctant to seek PAC services. Meanwhile, other organizations working with migrant communities provide transportation to MTC for women who have experienced complications from (unsafe) induced abortions and are in need of PAC. Organizations report that it is not uncommon for women to only seek treatment after an infection or other complications from the abortion has become "emergent," or when her health condition is such that it is "too late" for treatment.

Community attitudes

Most organizations and FGD participants report that the migrant community does not approve of induced abortion. According to participants, if a woman induces an abortion, the community will "look down" on her and "blame" her. Induced abortion is routinely associated with shame in migrant communities, and according to one participant, "If she's single they'll say that she goes with many men, if she's married, they'll gossip about her" [40].

Access to safe(r) abortion

Despite the significant role that unsafe abortion plays in maternal mortality and morbidity, there is a consensus among stakeholders that it is difficult for migrant women to access safe abortion in Thailand, even those who have pregnancies and health conditions that meet the legal exceptions. Noted barriers to access include a lack of facilities and trained providers, concern and confusion among providers about the law and its interpretation, security, language barriers, and reluctance among physicians to perform abortions based on personal moral or religious objections. Although abortion is legally permissible in cases in which the pregnancy is the result of rape, local interpretation of the law is such that for some facilities official documentation of the assault is required. The de facto involvement of Thai law enforcement chills migrant sexual assault survivors' access to abortion. Further, one respondent organization noted that even where a woman meets legal criteria for abortion, local provider discretion may prevent access to abortion. This organization cited one case where a woman died after a local doctor refused to perform a medically-indicated abortion.

There are reports of women accessing misoprostol in Myawaddy and using the medication for self-induction. However, respondent organizations noted a general concern about women accessing medications across the border, identifying lack of product quality and lack of adequate information accompanying medications as issues associated with purchasing medications in eastern Burma. There seems to be diverging opinions among organizations about the value of misoprostol as a safer option for abortion, with one interviewee expressing the belief that organizations that "understand women" are more willing to integrate misoprostol for induced abortion into their activities. Two stakeholder organizations stated that they have provided women with misoprostol in order to offer them safer, albeit illegal, abortion care. There have been no reported complications in these cases. SMRU clinics in migrant areas have reportedly observed an increase in PAC clients with fever, which they attribute to a possible increase in use of misoprostol to induce abortion, but SMRU noted that this increase may also be attributed to malaria and that further investigation is needed on this point.

FGD participants and stakeholder organizations referenced private clinics in Mae Sot, Bangkok, and Chiang Mai that perform safer abortions in a clinical setting for a fee; however respondents only had limited information about these facilities. Further, structural barriers make travel from the border to Bangkok and Chiang Mai prohibitive for most migrant women. Two organizations on the border have received training on manual vacuum aspiration

(MVA) for PAC, and though one respondent cited availability of MVA for safe abortion in Bangkok, there appears to be no access to MVA for induced abortion on the border with organizations limiting its use to PAC.

Migrant women also face structural barriers in seeking PAC. In particular, security serves as a challenge for women who seek PAC for complications from an unsafe abortion. One FGD participant reported that she suffered an infection from an unsafe abortion and twice attempted to seek care from MTC (about 5 miles away from her migrant community) but was unable to reach the clinic due to security checkpoints and traffic police that confiscated her money and sent her back to her community.

The evidence base: Misoprostol for early pregnancy termination

Misoprostol is one of three medications that are used worldwide for early pregnancy termination. Misoprostol is most effective when it is used in combination with another medication (either mifepristone or methotrexate). However, research has demonstrated that misoprostol can be used as a single agent to induce an abortion when other options of safe pregnancy termination are unavailable.

Misoprostol can be used to terminate an unwanted pregnancy through nine weeks' gestation (63 days after the last menstrual period). When the optimal regimen is used, misoprostol has a success rate of 75% to 85%. Although misoprostol is safer and more effective than the abortion practices typically used in legally restrictive settings, there are complications and risks associated with its use. Complications (such as infection or excessive bleeding), incomplete abortion, or ongoing pregnancy occur in 15%-25% of cases and require follow-up and additional treatment.

Recent studies suggest that the rate of ongoing pregnancy after misoprostol administration may be as high as 10%. Although the absolute risk of fetal anomaly after misoprostol exposure is low, at roughly 10 malformations per 1,000 exposed fetuses, evidence does link misoprostol exposure in utero to fetal anomalies of both the central nervous system and limbs. Women should be informed of these risks so that they can make an informed decision about the use of misoprostol for pregnancy termination [39, 40].

ASSESSMENT FINDINGS: REFUGEES

Family planning

Family planning counseling and supplies

Camp-based clinics provide counseling for family planning methods and serve as an access point for the distribution of contraception. For example, PPAT provides FP counseling in its five camp-based clinics. All services and supplies are free in the camps.

PPAT conducts outreach with three different groups; women, men, and adolescents. Weekly trainings with women focus on sexual and reproductive health and rights; trainings with men focus on the promotion of male involvement; adolescent trainings take place in the form of peer education



and discussion fora. IRC provides patient counseling that includes information about family planning and birth spacing practices. During these sessions, patients are taught how to most effectively and correctly use their chosen method. On follow-up visits, patients are given the opportunity to discuss side effects and “adverse” events, the use of the contraceptive method is reviewed, and, if continuation of the method is desired, additional cycles, doses, or supplies are provided, as appropriate, free of charge.

Camp-based organizations report distributing OCPs, hormonal injections, and male and female condoms. Referrals to Thai hospitals are available for IUDs and male and female sterilization procedures, while PPAT reports providing implants in the camp-based clinic. Organizations report that more women use hormonal injections and OCPs because men do not like to use condoms. According to PPAT, female condoms are not popular in the camps.

Context: 2010 new family planning clients in Umpiem Mai and Mae La refugee camps

Umpiem Mai, January-October 2010—987 (range 74-134 new FP clients/month), 3,370 continuing clients
Mae La, January-October 2010—2,902 (range 209-337 new FP clients/month), 6884 continuing clients

Context: 2009 Contraceptive prevalence rates in PPAT-serviced camps

Mae La, population 49,353—39%
Umpiem Mai, population 27,167—19%
Mae La Oon, population 16,320—28%
Mae Ra Ma Luang, population 18,209—24%

Emergency contraception

Emergency contraception is not widely discussed or used in camp settings. There is a general perception among organizations working in the camps that “camp culture” does not embrace the use of ECPs for all cases where it would be medically indicated. Indeed, there appears to be a bias in the camps against providing ECPs to women without first determining whether their case represents an adequate “emergency.” In cases of rape, KWO will refer women to the NGO clinic for ECPs but not in cases where the woman has forgotten to take her OCPs. Similarly, ECPs are available at IRC health facilities for sexual assault survivors who present within 72 hours of the incident, but not in other situations. However, provision of ECPs in the wake of sexual assault is complicated by the fact that women generally do not present soon enough to obtain the medication and thus overall use is low.

According to PPAT, the use of ECPs is generally not promoted because of concern that ECPs will be perceived as in conflict with “traditional community values.” But simultaneously there also appears to be widespread concern about the “misuse” (e.g., use in “non-emergency” situations) and/or repeated use of ECPs and the consequent side effects. Despite these challenges, there are some efforts taking place to inform women in camps about ECPs. In the five camps where PPAT provides reproductive health services and supplies, the organization trains volunteers and staff on ECPs, and includes information about ECPs in its family planning outreach. These outreach efforts include encouraging women that have “urgent problems with contraceptives” to come to the clinic “within 24 hours.”

Organizations operating in the camps sense a tension around the promotion of ECPs; concern was repeatedly expressed that efforts to incorporate ECPs into broader reproductive health or family planning programming could undermine community engagement efforts. In Mae La, SMRU reports that there is a need to engage in workshops to encourage the community to see the value of ECPs. According to SMRU, introducing ECPs without adequate community education and engagement would result in a loss of trust. An important component of such outreach would involve a word-of-mouth strategy within the camps as part of a concerted border-wide effort supported by data on unwanted pregnancy.

Family planning procedures

Organizations working in the camps note that the implant is more popular than the IUD. PPAT explained that in Karen culture, the IUD's location in uterus somehow brings "shame," whereas the implant's position in the arm is more acceptable to camp residents. In many cases the IUD is considered a "last resort" for women who are unable to use hormonal contraceptives because of hypertension or some other underlying health issue. When possible, PPAT refers to SMRU clinics for family planning procedures, and otherwise, to Thai public hospitals.

PPAT refers to Thai hospitals for vasectomy and tubal ligation. PPAT clinics at Mae La camp refer to Mae Ra Mat hospital, and IRC refers patients to Mae Hong Son and Khum Yum hospitals from Ban Mai Nai Soi and Ban Mae Surin. These referrals cover the cost of transportation as well as the procedure. KWO noted that most referrals for vasectomy and tubal ligation occur once a couple has had four to five children; if the couple has only two to three children women are generally counseled to use OCPs or injections.

PPAT reports fewer men undergoing sterilization than women due to the popular perception that a vasectomy leads to lowered sex drive and decreased overall strength. According to KWO, the community believes that male sterilization will lead to the inability to lift heavy things and work hard, as well as weight and energy loss. In the camp context, where the population's diet is limited to camp rations, the concern over energy loss is of particular concern. SMRU noted that there is strong resistance among men to sterilization in part because there is a persistent notion that family planning is a woman's responsibility. SMRU refers clients to PPAT, who coordinate referrals to outside hospitals for sterilization.

Context: Perspectives on male involvement in pregnancy prevention

Some husbands don't like to use family planning at all. Even if the wife is getting weak, or has a lot of work to take care of the children, the husband doesn't care. The wife follows the husband, so it's difficult to raise awareness about this issue. The husband says, "I'm getting a wife so I can have children. My wife is responsible for giving birth and it's my responsibility to find money and food to support the family." (Interview, Mae Sot, August, 8, 2010)

Much like misconceptions related to vasectomy, women are reluctant to undergo tubal ligations for fear of "losing energy." However, according to PPAT, women's knowledge of the physical tolls related to pregnancy and childbirth often outweighs their reticence about sterilization. This is born out in the camp statistics: In Umpiem Mai camp, from January through October 2010, of the 987 new family planning clients and 3,370 continuing family planning clients, there were four tubal ligations and zero vasectomies. In Mae La camp during the same period, there were 2,902 new family planning clients, 6,884 continuing clients, 60 tubal ligations and seven vasectomies [10]. PPAT asserts that women are better informed about family planning procedures than men and that there is a need for greater educational outreach among men in the camp communities.

Common barriers to family planning access among refugees

Despite the NGO presence in the camps and access to free reproductive healthcare, refugees living in Thailand's nine camps face a number of challenges in accessing family planning counseling, supplies, and procedures. As with cross-border and migrant populations, there is widespread misinformation among the refugee camp community regarding sterilization. Fear, rumor, and heightened concern about the side effects of contraception serve as barriers to use. Similar to cross-border and migrant communities, there appears to be reluctance among men in the camps to using condoms and young and unmarried populations face particular difficulties in accessing reproductive health and family planning information and supplies. PPAT noted the need to continue engaging in outreach and advocacy to change attitudes in the refugee community. According to PPAT, this is a slow process because Karen leaders in particular have not traditionally embraced family planning.

Maternal mortality

Women may access a skilled birth attendant at NGO-run clinics inside the refugee camps. For example, in Mae La Camp, SMRU has one delivery room, with an average of 120 deliveries each month. However, there are no facilities to perform cesarean sections in the camps, and camp-based NGOs refer women to Thai hospitals for such procedures. The rate of referral to Thai hospitals is 6% to 7% for Mae La, Mu Ka Thai, and Wan Pa, and the cesarean rate is 4% to 5%. In Ban Mai Nai Soi and Ban Mae Surin, IRC's reproductive and child health staff, including IRC midwives, attend deliveries. When necessary, patients are referred to either Mae Hong Son Hospital or Khum Yum hospital. In the IRC camps of Ban Nai Soi and Ban Mae Surin, there have been no reported maternal deaths since 2009. Still, the MMR in refugee camps may be higher than Thailand as a whole. Camp organizations also reported that there have been a number of suicides, including the suicide of a woman in 2011 in Mae La Oon camp, that have occurred after women have learned that they are pregnant.

Unsafe abortion

Abortion prevalence

Similar to cross-border and migrant populations, information about abortion prevalence in refugee camps is challenging to determine. Opposition to induced abortion is strong among camp religious and community leaders. Respondents report that the community will "blame" and "shame" women who terminate their pregnancies.

Some organizations report that they only rarely see unsafe abortion in the camps. For example, according to PPAT and KWO, abortion prevalence is low because of the increased use of family planning, and if a single woman is found to be pregnant, the community forces the couple to get married. Other organizations report that the rate of unsafe abortion in the camps is the same as in migrant communities. According to some camp-based healthcare workers, most women who seek abortions in the camps already have children. SMRU developed a survey to understand better the causes of pregnancy loss in the camps (spontaneous versus induced). Although women were reluctant to admit to having induced an abortion, SMRU reports that around 12% of its PAC clients reported having tried to terminate the pregnancy, most commonly through ingestion of Kay Thi Pan (a traditional medicine) or abdominal massage. Less than 1% of respondents reported using foreign objects, and only one respondent said that she induced abortion with misoprostol.

The health consequences from unsafe abortion as reported by camp-based organizations include heavy bleeding, loss of consciousness, and death. IRC reports that PAC patients usually present at the clinic with vaginal bleeding; the patient is admitted to the inpatient department and, depending on the patient's condition, referred to a Thai hospital for treatment. Women with incomplete abortions are routinely referred for hospital-based management. However, most organizations suggested that mortality from unsafe abortion in the refugee camps is less than other communities because women have access to camp-based facilities that provide PAC (SMRU, IRC) and family planning supplies. No camp-based NGOs provide abortions at their facilities.

Access to safe abortion

Only with a referral to a Thai hospital can women in the refugee camps access safe abortion care. According to one organization, if a patient appears to meet the legal exception under the Thai abortion law, she may be referred to the local public health center or hospital, where doctors will determine whether they can provide an abortion. However, although termination in the case of rape is allowed under Thai law, PPAT reports that referrals for abortion in the case of rape are extremely difficult given that involvement of the Thai authorities "is required." Therefore, most referrals for abortion care are provided to women for whom continuing the pregnancy threatens their health.

ASSESSMENT RECOMMENDATIONS

Although there are a plethora of organizations operating along the Thailand/Burma border, this assessment reveals that there continues to be significant unmet need for comprehensive reproductive health services. Importantly, many of the needs identified through this assessment are shared between cross-border, migrant, and refugee camp-based populations. Below we outline a series of recommendations; some center on the expansion of existing programs and projects while others focus on priorities for new efforts that both address unmet needs and increase coordination and information-sharing along the border. Undertaking any of these recommendations will require support from individual organizations, communities, and funders. As part of our assessment recommendations, we highlight areas that are especially in need of funding and resources from donors.

Improve access to high quality family planning information, counseling, and services

In all three communities there is considerable need to improve access to family planning information, counseling, and services. Although many family planning-related activities are being undertaken along the border, there is a general lack of coordination among the various organizations providing services. Enhanced sharing of information, including the outcomes of successful programs and interventions, has the potential to make a tremendous impact on establishing best practice models and ultimately addressing better the unmet family planning needs in all three communities.

The success of the SHIELD Project and the IOM Migrant Health Project suggests that one model for improving family planning access involves the integration of migrant

services with the existing Thai health system. However, building on these prior efforts will require funding. Reinstitution of funding for the IOM Migrant Health Project is an important first step. In the interim, border organizations should seek to deepen their coordination and engagement with the Thai MOPH to potentially identify avenues for future service integration.

Drop-in centers, such as those operated by MAP, BWU, and the ARHN Youth Center, also show a great deal of promise in addressing unmet family planning needs along the border. These centers provide culturally and linguistically appropriate family planning counseling, adolescent reproductive health education, supply



distribution, and referrals, thus mitigating a number of the structural barriers to access that are rife along the border. Exploring possibilities for creating additional drop-in centers is certainly a priority. However, in order for drop-in centers to meet community needs, they must have a sustained supply of pregnancy tests, OCPs, ECPs, male and female condoms, and hormonal injections, and there is a significant need for these centers to strengthen their relationships with the Thai sub-district health centers to ensure safe and timely referrals.

Both among health service providers and within border communities, there continues to be a significant amount of misinformation about family planning methods. This appears especially true of LARCs (and in particular IUDs) as well as male and female sterilization. The practices of organizations along the border, with respect to both provision and referrals, vary considerably. There is a considerable need for organizations working with all three border populations to develop evidence-based guidelines for the delivery of both LARC and sterilization services. Discussion among organizations has the potential to lead to border-wide norms and guidelines which would facilitate consistent access to services.

Improving access to LARC and sterilization services will also require additional training and education of health service providers. There is a need to establish ongoing training and technical support for IUD and implant insertion and removal, including with Thai health personnel at sub-district health centers and medics at Mae Tao Clinic. Further, integrating medically-accurate information about IUDs and sterilization procedures into existing reproductive trainings for health workers is critical. This is particularly true of training around IUDs, as there continues to be considerable misinformation about eligibility, risks, and complications among health workers.

Finally, lack of awareness of and misinformation about contraceptive methods among women and communities represents an ongoing challenge in all three communities. Increasing outreach activities—through peer health education, the dissemination of culturally and linguistically appropriate educational materials, and engagement with both civil and religious community leaders—are priorities in all three settings along the border. There is also a significant need to engage with men in all three communities. Organizations operating along the border could benefit from having more opportunities to share their experiences and exchange resources.

Undertake efforts to increase awareness of and expand access to emergency contraception

Use of ECPs is low among all three populations in the region. Health workers, program managers, and community members—particularly in cross-border and migrant settings—lack information about ECPs. Lack of information and misinformation about ECPs impact both requests for the medication and provision practices. Overall, more information and education are needed for both the public and stakeholder organizations.

There is a considerable need for organizations working in all three areas to develop evidence-based ECP service delivery guidelines and protocols. This includes offering the medication to all women who want to prevent pregnancy and who have had unprotected or underprotected sexual intercourse within the 120 hour window for use. Camp-based clinics in particular have developed policies that restrict ECP access to sexual assault survivors. Although meeting the needs of this population is important, provision of ECPs should not be limited to this subset of women. Creating opportunities for organizations to discuss and share their provision protocols could be a first step in establishing border-wide norms and service delivery guidelines. There is also a need—particularly in cross-border areas—to ensure that an adequate and reliable supply of ECPs is available.

Beyond the establishment of organizational protocols, additional health service provider trainings are needed to ensure that provision of ECPs is evidence-based. These types of trainings should include detailed discussions of the evidence-based practices for offering the medication and values clarification exercises to explore individual provider biases surrounding provision. Notably, trainings should include information about the realities of women's use (and repeat use) of ECPs and dispel misinformation about the "abuse" or "misuse" of ECPs. However, efforts to improve ECP service delivery will likely be for naught if women lack awareness of the medication or if community leaders oppose distribution. Organizations working with all three communities should increase outreach and education campaigns to raise community awareness about ECPs.

Increase access to skilled birth attendants

Given the numerous challenges facing organizations in the cross-border setting, sustainable, multi-year funding that includes organizational core costs is crucial for long-term interventions to reduce maternal mortality in eastern Burma. Successful program models, such as the MOM Project, offer examples of the impact of long-term, comprehensive community-level interventions to increase access to emergency obstetric care, skilled birth attendants, and other reproductive health services. Training models that can address and overcome the realities of medic turnover are of high priority. Funding should be made available for longer term trainings, particularly for EmOC and the integration of EmOC training with other reproductive health service training, and for general funds to support human resources, supplies, and other program costs. In the cross-border setting where PPH is still the leading cause of mortality, it is imperative to ensure that health workers have access to a sustainable supply of medications for PPH prevention and treatment (including misoprostol).

In communities near the border in eastern Burma, as well as in more isolated migrant communities outside Mae Sot, organizations should scale-up referrals to Thai or CBO clinics with skilled birth attendants. In the migrant community, security and the high cost of regional travel represent the greatest barriers to accessing a skilled birth attendant. Efforts should be made to identify ways to reduce the cost of travel for migrants and increase the reliability of referrals to facilities with a skilled birth attendant.



Develop strategies to reduce harm from unsafe abortion

Harm from unsafe abortion continues to serve as a significant factor in maternal death and morbidity across the region. Although there are limitations as to what can be achieved given the legal status of abortion in both Burma and Thailand, there is a considerable need to begin a comprehensive dialogue about unsafe abortion in migrant, refugee, and cross-border areas. These types of discussions should include information about Thai abortion law, including accurate information about the legal exceptions, the health risks associated with unsafe abortion practices, and the possibilities for expanding access to safe(r) services, either through referrals or with the use of misoprostol. Any discussion of misoprostol as a method for early pregnancy termination should include evidenced-information about the risks and benefits (both legal and medical) of use.

These discussions could be undertaken through the framework of a policy forum as well as through conferences,

workshops, and trainings, both among service-providing organizations and the broader communities in which they serve. There is a particular need to conduct trainings and outreach in cross-border and migrant areas and to increase awareness of the risks of unsafe abortion among TBAs. Finally, there is a need to foster more collaboration between health providers and the Thai MOPH in order to develop protocols for the referral of Burmese migrants and refugees for safe and legal abortion in Thailand. Identifying sources of support for these activities is a considerable priority; in the absence of developing strategies to increase women's access to legal and safe and/or safe(r) abortion care, unsafe abortion and the consequent morbidity and mortality will continue to present throughout the region.

Expand efforts to address adolescent reproductive health needs

In all three populations, there is a high degree of variability in the availability of comprehensive ARH services. Information, counseling, and the provision of services are concentrated among those organizations that are ARH-focused and those with dedicated adolescent programs. There is a considerable need to undertake efforts to increase the visibility of those organizations and networks that are already providing services to adolescents and to provide support to these organizations such that they can expand their existing programs. But there is also a significant need to build capacity and coordination among all organizations providing reproductive health services such that the needs of adolescents and unmarried adults can be better addressed. Organizations serving all three populations should review their outreach strategies and service delivery guidelines to identify gaps in services for adolescents. Importantly, this type of review should be undertaken in tandem with an exploration of whether assumptions about the sexual behaviors and reproductive health needs of adolescents and unmarried populations are impacting the accessibility of services.

In migrant areas, existing structures such as the ARHN and ARHZ should be supported and strengthened. Peer education programs that are currently provided by CBOs and coordinated by the networks appear to be particularly successful in engaging with adolescent about sexual and reproductive health. Increasing the capacity of peer health educators such that they can provide both information and basic family planning services remains a significant priority. Furthermore, there is a need for the establishment of programs mirroring the ARHN and ARHZ networks in the Shan migrant community in Fang District. Finally, the ARHN Youth Center in Mae Sot represents an important resource for adolescents. However, additional donor support will be required to consistently cover the operating costs of the Youth Center and continue and expand training and outreach activities. Establishing similar types of centers in other areas (such as Chiang Mai and Fang District) has the potential to make an important contribution to addressing adolescent reproductive health needs among migrants.

Establish additional avenues for communication and coordination

The success of joint projects such as the SHIELD Project and the MOM Project emphasize the importance of coordination among stakeholder organizations. Additional donor support is needed for reproductive health coordination in the Thailand-Burma border region. Specific activities should include a web-based portal for communication, information-sharing, and dissemination of resources, materials, and documents among border area organizations. There is a particular need to increase coordination, trust, and communication between migrant and camp-based organizations.

A number of organizations operating along the border collect data on the populations that they survey, conduct surveys, and undertake program evaluations. Identifying ways to better share data once it is collected would help to ensure that efforts are not duplicative and would provide an important opportunity for documenting and disseminating successful programs and interventions. Finally, in addition to surveys specifically dedicated to reproductive health, such as those being carried out by MOM, BPHWT, and KDHW, there is a need to include reproductive health-related questions on other broader border surveys. By coordinating and sharing information, organizations along the border that focus on reproductive health will be better able to identify priority reproductive health-related questions for inclusion in these broader research efforts.

CONCLUSION

In conclusion, this report identifies and discusses the unmet reproductive health needs of cross-border populations, migrants, and refugees in the Thailand-Burma border region. Our findings demonstrate a pervasive lack of access to family planning resources, the need for increased access to skilled birth attendants, and the need to reduce harm from unsafe abortion among all three populations. For cross-border and migrant populations in particular, reproductive health indicators demonstrate limited access to family planning counseling, supplies, and procedures, while structural barriers and lack of evidence-based reproductive health education and information restricts access to limited resources that are already available for all three populations.

Organizations on the border are doing incredible work in a very challenging setting. While addressing gaps in reproductive health will require overcoming seemingly impossible regional challenges, including ongoing conflict and the attendant security threats in eastern Burma, abortion policies that limit access to safe abortion on both sides of the border, and structural challenges faced by migrants in Thailand, organizations have made demonstrated headway in improving health outcomes despite these constraints. The Thailand-Burma border encompasses some of the most vulnerable populations in the world, and although organizations continue to implement successful projects to close gaps in reproductive health services, support from a broader community of organizations and funders is imperative to continue improving health outcomes for populations in the region. Resources are needed to integrate best practices into community-based efforts, rethink strategies for preventing unplanned pregnancy and reducing harm from unsafe abortion, train a sustainable supply of high-quality health workers and arm them with essential medications, and improve communication and coordination among organizations serving the border area's overlapping groups of cross-border populations, migrants, and refugees.

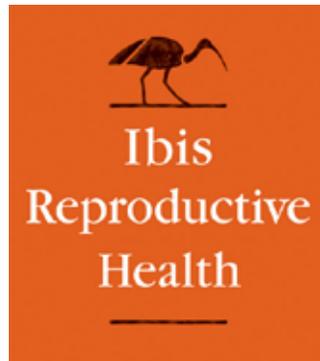
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APPENDIX A: MAP OF THE THAILAND-BURMA BORDER REGION





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Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide. We accomplish our mission by conducting original clinical and social science research, leveraging existing research, producing educational resources, and promoting policies and practices that support sexual and reproductive rights and health.