SEPARATED BY BORDERS UNITED IN NEED

An assessment of reproductive health on the Thailand-Burma border

Authors

Margaret Hobstetter, JD, MPH
Meredith Walsh, MPH, RN
Jennifer Leigh, MPH
Catherine I. Lee, MPH
Cari Sietstra, JD
Angel M. Foster, DPhil, MD, AM

This is the executive summary of Hobstetter M, Walsh M, Leigh J, Lee C, Sietstra C, Foster A. *Separated by borders, united in need: An assessment of reproductive health on the Thailand-Burma border.* Cambridge, MA: Ibis Reproductive Health, 2012.

An electronic version of the full report (in English only) as well as executive summaries and key findings in Burmese, English, Karen, and Thai can be found at: http://ibisreproductivehealth.org/work/other/thaiburmaborder.cfm

Photos & graphic design by Nancy Chuang.

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).

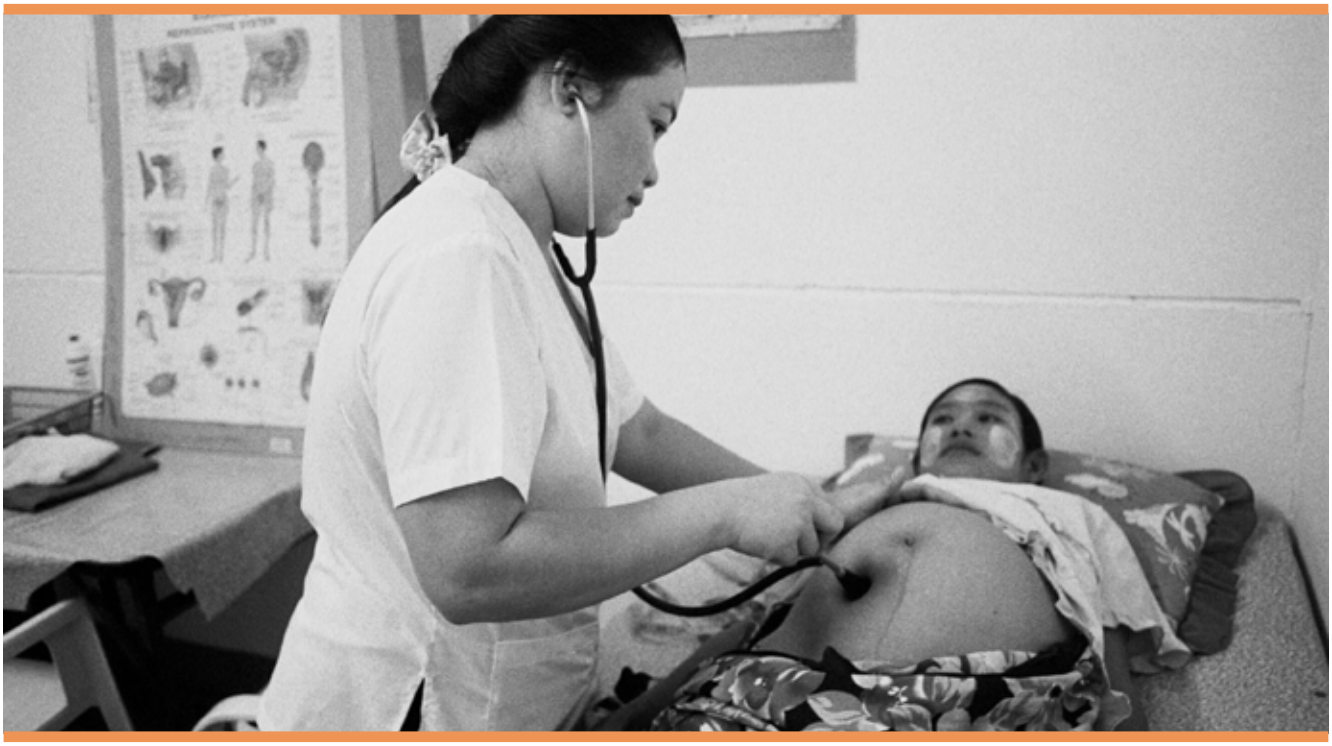
Common barriers to family planning counseling, supplies, and procedures include distance, lack of funds, distrust

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.