Working Our Way Back Home

Fertility and pregnancy loss on the Thai-Burma border

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About the cover

The cover artwork is donated by Maung Maung Tinn, artist, health worker, philosopher, who can often be found in the teashop at the Mae Tao Clinic sharing his views. When he gave this picture he told the story. The title of the painting is ...

‘We know we should not be in another country as illegal people but we have to’.

He went on to explain the inspiration...

*We are from Burma and we stay here for economic and human rights reasons. The economic conditions are bad because the government of Burma is selfish. They only think of power for themselves. The people cover themselves because they are ashamed. The Thai officials are watching them. The setting is June 2002 when 500 people were arrested and sent home*
to Burma across the Moei River. In the picture you can see they are treated like criminals. Maybe they know they should have registration papers but it is expensive. They cannot do registration and that is why they were arrested. They are kept in prison for one or two nights and then they are deported to Burma. They often return very shortly after that. I feel sad. Nobody wants to live like this and be treated like a criminal. I don’t have papers. People can treat us as they wish, we have no rights. We can be treated badly or disappeared and nobody knows.

As most of the people who helped to prepare this report, as well as the research participants find themselves in this situation the painting is a very appropriate one for the cover.
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Preface and thanks

It is my sincere wish that this report will benefit the Burmese women and men who travel to Thailand in hope of finding security and a better life. I hope that the report can inspire health workers, teachers, politicians, policy makers, and Thai and Burmese community leaders to consider how they could use this information to benefit the lives of people who look to them for leadership.

This research was made possible by the dedicated staff at the Mae Tao Clinic who gave their time and insights for which I am grateful. The Mae Tao Clinic is home, school, temple, church, welfare agency, public relations department and a unique model of refugee-led primary health care that treats thousands of Burmese migrant workers and refugees every year. The Mae Tao staff in Reproductive In-patient and Out-patient departments helped design the interviews, participated in the interviews and then recruited their female patients as they approached recovery and discharge. They collected the ‘abortion sticks’ from their patient’s wombs and shared their sorrows over the many tragedies witnessed. The staff in Medical Records diligently recalled the hundreds of patients’ medical records despite their own heavy workloads. The research assistants were not only skilled translators of language and culture but also compassionate, patient people who could speak with women and men about some of the most intimate moments of their lives. Naw Roseline was particularly important during the research process and later Mitcharai edited the report. We are indebted to many others in the community who assisted in a multitude of ways and Naw Dah and Ko Latt were also very helpful.

I would also like to give credit and thanks to the medical and nursing staff at the Mae Sot public hospital who are also very concerned by the amount of sickness due to induced abortion in the Burmese community. Dr Lek Nopdonrattakoon, Chief of Department of Obstetrics and Gynaecology gave careful advice and supervised the research in his department. Thai staff also spend valuable time and resources healing Burmese women after botched abortions.

The Key Centre for Women’s Health in Society, the University of Melbourne is acknowledged for financial and intellectual support, and in particular Dr Andrea Whittaker has provided her time and experience. Several non government organisations in Thailand provided information such as statistics, interviews, reports which have helped in the
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production of this report. I thank all the proof readers and especially Brenda Belak, Inge Sterk, Tara Sullivan and Dr Dan for their guidance and accept that any mistakes or misunderstanding are my own. Inge also gave permission to reprint some photographs. This report will appear in Burmese language and possibly others and it can be found in the On-Line Burma/Myanmar Library. If anyone would like further information please contact me or Dr Cynthia Maung.

Suzanne Belton
PhD Scholar and midwife
Oxford, UK, 2004
Statement from Dr. Cynthia

The world today has been facing the challenge of population migration issues. People are forcibly displaced within their own countries, to neighbouring countries across the region and to countries far from their countries of origin. Due to political conflict, chronic poverty and human rights violations people seek opportunities and security. International Organization for Migration figures estimate that 3% of the world’s population are migrants, the figures for 2002 were 175 million. Between 80 and 100 million of these migrants are migrant workers.

Up to half of all migrants are women and girls, many of whom are independent rather than migrating as part of a family. Most job opportunities for women are in unregulated sectors (domestic work, informal casual labour (off the books), including the sex industry. Open to abuse with no protection by national or international laws. Low salaries, long hours, no time off, no sick pay, restrictions on their freedom of movement, and dangerous working conditions are all common conditions for women migrants to live with. They are also at high risk of violence and sexual abuse by employers.

For migrant workers their vulnerability is compounded by the journey to the country of work, this often involves illegal border crossings. This leaves them open to abuse by illegal recruitment agencies who offer “safe” travel usually at exorbitant prices. As the price is often too high to pay back agents may exact their fees in other ways with coercion, force, illegal sex work etc.

In addition female migrant workers face general discrimination, racism and stigmatisation. Governments and media perpetuate negative stereotypes of migrant workers as lazy, stealing jobs, spreading disease, and trafficking drugs. Without doubt, migrant problems (whether legal or not) are worse for women.

When Burmese people migrate to Thailand, community structures begin to disintegrate and family units lose their cohesion. Working conditions are not supportive of traditional community and family mechanisms and behaviours. It becomes difficult for women to address their domestic problems effectively.
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In Thailand, government policies discourage pregnant migrant women from working. Employer regulations mean that children of migrant workers cannot be accommodated. Workers often have to live at the workplace. But many employers will not allow the children to stay with their parents. Most employers do not allow parents to bring their children to work. Bringing a child into this environment is a difficult decision for people to make. When the child is unplanned, there are more difficult decisions to make.

Accessing services for reproductive health matters is difficult. There are many barriers: limited access to information and if information on services is available, these services are limited. Women may not know where and how to access the services. If they are far from the workplace then women may face fear of arrest on the journey. Language barriers may also prevent them accessing the services.

The most pressing policy issues at both international and national levels concern protection of the human rights of the most vulnerable groups, including especially women and girls. It is imperative that migrant women can have their reproductive rights recognised and be empowered to organise themselves to improve their working conditions and the conditions for them and their families.

There are powerful social stigmas attached to abortion and family planning for unmarried women has equally strong cultural stigmas attached. These attitudes are barriers to women coming forward to receive contraception or post abortion care. If they do come forward they face discrimination by health workers who also hold negative opinions of the women. It is imperative that appropriate technical, social and cultural support is provided to women. Improvements must be made in client/ health provider communications to ensure the continuity of services.

Effective Reproductive Health Programmes require collaboration among all health services: Thai hospitals, non-governmental organisations. It is also imperative that community organisations be recognised and empowered to represent the communities they work for. Without input from migrant women, the impact of any strategy will be minimal.

Dr. Cynthia Maung
Mae Tao Clinic
Glossary

D & C (Dilation and curette)
A surgical method to remove the products from the womb.

RH (Reproductive Health)
All aspects of sexually related health care.

RH OPD (Reproductive Health Out Patient Department)
Where women are treated and need to stay in a bed.

RH IPD (Reproductive Health In Patient Department)
Where women are treated and then go home.

Abortion
Early pregnancy loss

Induced abortion
To end a pregnancy by intention and action.

Menstrual regulation
Early evacuation of the womb often before pregnancy is confirmed.

Spontaneous abortion or miscarriage
Where a pregnancy ends by unknown causes, which are often genetic and are very common.

Missed abortion (MA)
Where a foetus dies but remains inside the woman until it is eventually expelled.

Lay midwife Lay midwife (Let thay)
A person who has learnt to deliver babies and care for women by informal teaching methods.

Abortionist Abortionist (Jay zar let thay)
A midwife who accepts money for abortion services – it has a negative meaning similar to mercenary.

IUD (Intra-Uterine Device)

Weakness (Ah neh)
To lack power or strength

Hot medicine (Thway say)
A culturally shared belief regarding the qualities of food, drink and medicine.

UNHCR
United Nations High Commissioner for Refugees
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• Please note that personal names which appear in this report have been changed.

• The photographs do not depict abortionists or any women connected with the health problems discussed in this report.

• This report is based in social public health and does not attempt to find solutions to address the spiritual issues for Buddhists, Christians or Muslims that arise from induced abortion.

• Furthermore, women were asked to describe their own ethnic identity and the labels used in this report reflect women’s descriptions of themselves. Burmese people’s ethnic identity is complex and politicised. Much prejudice is caused by labelling but we wanted to show the diversity of women who contributed to the research and for whom unplanned pregnancy is a serious problem.
Findings

Key findings from the research show that:

While unplanned pregnancy and abortion are a large problem, they can be prevented

- Post abortion care at Thai and Burmese health facilities takes large amounts of health resources.
- At least a third of women with post abortion complications have self-induced abortions.
- Men and women have low levels of knowledge about modern methods of contraception.
- Temporary contraceptive information or methods are not offered to women during post abortion care in the Mae Sot Hospital but are offered 6 weeks after discharge.

Many women are affected by unplanned pregnancies ~

- The vast majority of women are married and two thirds have children.
- A third of women have five or more pregnancies, which is a health risk in itself.

The way the pregnancy ends can negatively affect women’s health and wellbeing ~

- Unqualified abortionists and home remedies are the only recourse women have to end an unwanted pregnancy.
- Women know of and use a wide variety of methods to end their pregnancy including self-medication with multinational and Burmese medicines, drinking ginger and whisky, vigorous pelvic pummelling and insertion of objects into the sex organs.
- Post abortion treatment in hospital can be expensive if a woman does not have a work permit or is not referred by Mae Tao Clinic and can leave her with debts.

Women are pressured by social and political circumstances to end their pregnancies~

- Women are often pressured by employers, husbands and the fear of unemployment to end their pregnancies.
- Some women report domestic violence as influencing their decision to abort.
Women were attempting to limit their fertility in many different ways ~

- Most women and lay midwives classified menstrual regulation and abortion as traditional methods of fertility control.
- Most women accepted a diverse range of temporary and permanent contraceptive methods from the Mae Tao Clinic staff while they were still in-patients.

The nature of forced displacement and lack of human rights directly effects reproductive health ~

- Having a work permit does not necessarily offer protection to women, as there is scrutiny to ensure a woman is not pregnant when a permit is issued.
  - As workers without work permits can be arrested and deported by Thai police, women are reluctant to travel to any type of health service and often wait until they are very unwell.
  - Burmese women as non-citizens are not included in Thai death statistics at a national level so the deaths of Burmese women go unnoticed, by both Thai and Union of Myanmar authorities.

Recommendations for health workers, teachers of health and researchers

- Thai health workers would be greatly assisted by employing bi-cultural health workers who can teach and explain all aspects of post abortion care, such as nutrition, hygiene and fertility issues in Karen and Burman languages as well as help doctors collect informed consent for medical and surgical procedures.
- Comparative research on abortion between institutions or people's experience is not possible and definitions need to be clarified from the beginning.
- Definitions found in ‘classic’ medical textbooks particularly those from countries where induced abortion is legalised as an elective surgical or medical procedure, should be ‘localised’ and taught with the experience and definitions of pregnancy loss found on the border.
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- Regular random reviews of health records should continue for monitoring and evaluation purposes.
- Health workers should be encouraged to record a full social and gynae/obstetric history for each woman, unless it is apparent from the sum of all past entries.
- Health workers in the Mae Tao Clinic need more time with patients in order to provide complete post abortion care in the out patient department.
- All women should receive education and counselling on family planning and especially after any type of abortion.
- Women, especially those at higher risk, such as possible induced abortion, history of repeat abortions, very young or five or more pregnancies should be admitted overnight for evaluation, education and counseling.
- Temporary contraceptive methods must be offered to women while they are in-patients.
- The Mae Tao family planning clinic as an out patient and also out reach service should be expanded and more men should take on the role of health worker in this area.
- Women and men should be informed in their own language that fertility will return two weeks after any kind of abortion and given a choice of temporary modern contraceptives at discharge from a health service.
- Thai health workers would be greatly assisted by employing bi-cultural health workers who can teach and explain all aspects of post abortion care, such as nutrition, hygiene and fertility issues in Karen and Burman languages. They could also help doctors collect informed consent for medical and surgical procedures.
- Thai health workers should direct Burmese women to the Mae Tao Clinic reproductive health services if they feel they cannot provide complete health care.
- The links between Mae Sot Hospital and Mae Tao Clinic which already exist should be enhanced to improve referral and information exchanges.
- Women need to be informed of the different risks involved in the various abortion techniques. Some are more unsafe than others.
- Lay midwives should be taught about unsafe abortion and its consequences as well as modern methods of family planning.
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- Liaison workers who can re-supply lay midwives with birth kits and assist with referral should be promoted.
- Signs of chills, fever, excessive blood loss and increasing pain are life threatening and women need assistance to attend hospital – health workers should consider how referral networks can be improved between lay midwives, Thai and Burmese health service providers.
- Health and welfare workers should not criminalise women or lay midwives who choose abortion but rather promote education and safer ways of fertility control.
- Health workers should be trained to recognise and discuss violence in family relationships with women and men.
- Women should be screened for domestic violence and not given male controlled methods of contraception if they have little influence in the relationship.
- Sterilisation should be offered to women in their own language but with time to consider the implications of a permanent method of contraception.
- Public health education projects should include men and outline the benefits of family planning to them, for the health of their wives and children.
- Men should be offered family planning information in culturally appropriate ways by male health workers.
- Women who complain of ah nee or who are diagnosed with ‘weakness’ by health workers, should be offered counselling and asked if they wish to delay the next baby until they feel stronger, as they are at risk of an unsafe abortion.
- Public health education programmes would be useful and effective in this population as they are more stable than assumed.
- Out reach programmes with the assistance of Thai public health officials should be implemented.
- All public health information should be designed at a primary school level of understanding.
- Health education and information should be given in Burman as well as Sgaw Karen - or other appropriate common languages.
- Short courses for pharmacy assistants on how to prescribe emergency contraception and other contraceptives correctly,
should be implemented as most women buy over the counter and do not seek a health professional’s advice.

**Recommendations for organisations interested in advocacy and community level projects**

- Women’s groups or religious or welfare groups should design community support programmes to assist women with ‘weakness’.
- Family planning projects should be promoted as improving the health and survival rates of women and children for a strong culture.
- The production of factual, calm and informative health information on abortion and contraception should be produced for the diverse Burmese community.
- Songs, plays, picture books, posters, radio programmes, videos which are interesting, as well as educational should be produced in multiple local languages.
- Outreach projects and primary health clinics on sexual health issues in the markets, factories, construction sites and farms should be promoted which target men and women.
- Health information products should also be sent into Burma.
- Providing educational opportunities for children is important as it gives a sense of hope for the future.
- Children should be offered some identity papers so they may go to school and eventually back to Burma with their parents as well as go to Thai schools.
- Organisations which support temporary nurturing and long term adoption of Burmese children should be promoted.
- Male community leaders should denounce all violence against women and assist women in their community to live safely.
- Safe houses where women and children can live without fear of male violence should be in all communities.
- Perpetrators of violence should be sanctioned in culturally appropriate ways and when power sharing in Burma occurs, marriage, assault, and rape laws should be reviewed.
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- Non government workers supporting migrant workers should develop gender sensitive work practices – supporting claims toward equity of pay and maternity assistance for women in the paid workforce being examples.
- Young couples who need to save money for their future should be helped to delay their family.
- Thai public health workers should have access to work places such as factories and farms to offer culturally appropriate health education to Burmese migrant workers.
- Men and women workers should have the option of separate secure accommodation, separate toilets and bathing facilities.
- Non government workers could develop saving funds schemes or micro lending type projects to help families out of debt situations.
- Measures to reform and liberalise Thai and Burmese law which criminalise women who choose abortion would be beneficial.

Recommendations for donors

- Funding programmes or projects which address reproductive health, especially family planning and violence against women aimed at Burmese men and women are needed.
- Projects or programmes which assist women out of poverty should be funded.
- Strengthening links and trust between Burmese and Thai organisations is a priority.
- Training should be offered to Thai partners so that skill levels are similar.
- Innovative and creative ways to impart reproductive health messages should be supported.
- Products prepared for border populations may well be suitable to send into Burma where reproductive health education and information appears to be very low.
Recommendations for health policy makers, international agencies and governments

- Burmese women’s deaths should be reviewed at a local level by obstetricians, midwives, and public health workers.
- All organisations which provide reproductive health services to the displaced Burmese population should share maternal mortality and morbidity statistics.
- General health data should be sent to the Myawaddy Township hospital to notify the health director of how many of his patients were treated in Thailand.
- Burmese women’s maternal mortality should be recorded at the national level in Thailand.
- Health statistics and costs should be supplied to the Union of Myanmar Department of Health and they should be asked to contribute to Burmese women’s health in Thailand.
- An inter-agency, inter-organisation group should collect Burmese maternal mortality and morbidity data in Thailand which should be shared with World Health Organisation, UNFPA and ultimately the Union of Myanmar Minister of Health.
- Thai Government should restrict the access of the general public to some medications particularly hormone injections, oxytocics, high dose oral contraceptive pills (> 0.30 mcg oestrogen) and hormonal preparations used during menopause.
- Thai Government should monitor the working conditions of Burmese workers and implement the laws that do exist to protect workers rights.
- Thai Government should present a special report to the UN CEDAW committee on how they prevent discrimination against Burmese women who live and work in Thailand.
- The Union of Myanmar should present a special report to the UN CEDAW committee on the issue of women migrating to work in Thailand and how these women’s human rights, including reproductive health rights, are protected during the whole cycle of leaving and returning to their home country.
Section 1

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Section 1
Is there a problem?

Between four to five hundred women are treated at the Mae Tao Clinic each year for the complications of an early pregnancy loss. And at the local Thai public hospital several hundred Burmese women lay in beds recovering from complicated pregnancy losses annually.

At least one third of these women have ended their own pregnancy and two thirds have natural miscarriages. This raises several issues concerning the limited resources available to treat life threatening obstetric emergencies like the complications of all types of early pregnancy loss (abortion) and the emotional and social impact on individuals, families and the community. Women suffer pain, blood loss, and damage to their internal organs as well as impaired future fertility, sterility and occasionally death.

They are also socially vilified for the act of induced abortion and are considered ‘bad women’ or ‘terrible mothers’. This is complicated further by the fact that these women are not in their own country and are often undocumented people. It raises many questions to consider:

- what are the women entitled to,
- why are there so many women who do not want to be pregnant,
- why don’t the women control their fertility,
- what do their husbands think about the problem,
- should the Thai Government pay for Burmese people’s health care,
- how can a small amount of health resources be shared,
- and how can we prevent this health problem before it happens?

These are not easy questions to answer.
Objectives

The objectives of this study are:

- To describe the issue of fertility, unwanted pregnancy and pregnancy loss for Burmese women living in Thailand outside of the United Nations High Commissioner for Refugees system of camps
- To quantify the number of admissions and women presenting to Burmese and Thai led public health services for post abortion problems
- To identify demographic, bio-medical and socially relevant information in women with any type of pregnancy loss
- To document the methods which Burmese women use to regulate fertility
- To analyse the causes and prevention of unsafe abortion practices
- To analyse fertility outcomes in relation to the socio-political situation in Thailand and between Burma and Thailand and particularly forced migrations
- To consider the link between fertility outcomes and reproductive health rights
- To suggest ways to improve the situation
A 'culture of abortion' in Burma

Burmese people bring their own knowledge and health behaviours with them to Thailand and while it is not easy to get good quality information from inside Burma, there are some indicators that a ‘culture of abortion’ already exists. This is not something Burmese women do just because they are in Thailand.

Abortion is found to be one of the top ten health problems stated by the Union of Myanmar Ministry of Health as a priority, and programmes for post abortion care and family planning are now implemented at the township level with doctors, midwives and traditional midwives in an attempt to improve the situation (Thein Thein Htay, Josephine Sauvarin et al. 2003).

Individual authors like Ba-Thike (Ba-Thike 1997) have demonstrated that 20% of all admissions to hospitals comprise abortion complications with the resulting high maternal death rates. Nationwide surveys of Shan State, Mon State and Mandalay Division also show high levels of maternal death directly related to abortion and low levels of modern contraceptive use (UNFPA and Department of Health Union of Myanmar 1999). Half of the women are estimated to die at home (UNFPA and Department of Health Union of Myanmar 1999).

An Australian anthropologist (Skidmore 2003:88) talks about the situation for Burmese women inside Burma.

*Unwanted pregnancies are another aspect of a saga of poverty and gender-based violence, constituting further evidence of what Famer (1996) calls “structural suffering.”*

*Contraceptives are expensive and unreliable since they are often past their use-by date. Burmese women in the townships prefer injectables, since this eliminates the need to try and remember to take pills on a daily basis. Women seldom record the date of their last contraceptive injection, however, and forget when the next one is due.*

*Even more common is a lack of money to pay for regular injections. Intra-uterine devices are also popular because they also obviate the need to use regular contraception.*
Abortion is illegal and human rights groups have called for its legalization in Myanmar. Sterilization is performed in government hospitals and women are keen to avail themselves of this service. However, it is a costly and bureaucratically cumbersome process, and so relatively few go forward with the procedure. In interviews with over 400 women of reproductive age, sterilization was the main reason given for women choosing to have their second and successive children in a hospital (where sterilization can be performed after the birth). Approximately three percent of husbands have vasectomies, but this is illegal except for military personnel. Menstrual regulation (of which abortion is one possible outcome) is the primary method of birth spacing in Myanmar (Skidmore 1997a,b).

Menstrual regulation and other traditional practices of contraception and abortion are used in the estimated 40% of the country not covered by basic medical services, and in these areas, infant mortality rates are almost 400% higher than in areas where basic health services exist (UNICEF 1995).

Thus we can see a pattern of health behaviour that is systemic in nature, interlinked with social and cultural issues that flow over the borders of nation states with the variety of people who come to Thailand.
Other relevant research

There is very little research available to readers on reproductive health problems in populations that are forced to migrate, especially those outside of camp systems. Due to the difficulty in reaching populations who by their nature, try to avoid detection, there is little to compare our findings.

There are good examples of health survey research on the border conducted with communities not in camps from which to draw conclusions about the baseline reproductive health and these show low levels of sexual health knowledge around pregnancy, HIV or STI issues (Caouette, Kritaya Archanvanitkul et al. 2000; Mullany, Cynthia Maung et al. 2003).

The largest and most comprehensive research conducted on the reproductive health issues and specifically abortion in migrant workers is *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand* by Therese Caouette, Kritaya Archanvanitkul and Hnin Hnin Pyne (Caouette, Kritaya Archanvanitkul et al. 2000).

By using questionnaires, focus groups and observations they recorded the responses of 513 women and 461 men who lived in Chiangmai, Mahachai and Ranong on topics such as migration routes, work conditions, violence, sexual health and mobility. The general picture is of a mixed flow of migrants, who live and work in extremely difficult circumstances with very limited access to health care in Thailand.

Violence both at the level of the local community and that inflicted by state actors is common and despite their onerous living conditions, the Burmese planned to remain and work in Thailand. Health knowledge and information was very low and ‘the type of health care chosen by pregnant women migrants in Ranong was influenced by access, or lack thereof, to services in a formal health care system, convenience or travel, ability, or lack thereof, to speak Thai, cost, and reliance on employer.’ (Caouette, Kritaya Archanvanitkul et al. 2000:148).
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They questioned Burmese people who were Shan, Mon and Tavoy. Many had experienced an unwanted pregnancy, 99 (17%) of whom had attempted to abort. Half of this number had aborted successfully. When they were asked who did the abortion, the informants said themselves (30%), the traditional birth attendant (44%), health personnel (18%) and other people, for example husbands (8%). The migrant workers reported using herbal medicines, injections, massages and the insertion of objects into genital organs.

The respondents in *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand* were very candid which showed women and men’s willingness to talk about this difficult topic. They talk about the methods used to abort an unwanted pregnancy but also the desperation of the act.

The reasons given for the abortions were unmarried, too many children and not living in secure conditions, as well as a lack of access to reliable contraception. This research shows that people are prepared to speak about acts which they understand are illegal, dangerous and not approved of in their community.

It also raises the question of the role of the ‘traditional birth attendant’ as not just a woman who assists with births but who is much more a health worker with a diverse practice. Additionally, it is clear that many migrant workers education is low and access to sexual health information or contraceptive supplies is not common in Burma and they bring this level of sexual health and practices with them into Thailand. In fact many respondents reported their knowledge increased when they entered Thailand. Burmese women’s sexuality and sexual pleasure rarely appear in the literature. Other authors do discuss the unmentionable nature of sex and the double standards that discriminate against women (Skidmore 1997; Umemoto 1998). Motherhood and reproductive health needs do not cease during periods of instability or migration and indeed become even more pressing. Caouette, Archavanitkul and Hnin Hnin Pyne state the lack of access to health care and education for displaced Burmese in either Burma or Thailand leads to ‘high maternal mortality and morbidity rates, unwanted pregnancies, unsafe abortions and sexually transmitted diseases (including HIV/AIDS)’ (Caouette, Archavanitkul, Hnin Hnin Pyne 2000: 28).

There is no study of abortion inside the camp system except one master’s thesis from Mahidol University titled *Miscarriage among*
displaced people: A case study of Karen women in Tak Province, Thailand (Suksinchai Saowasphak 1999). She and her female assistants surveyed 900 married women who had lived in the camp for nine years on average. Unfortunately although the author did ask about all pregnancy outcomes she concludes that the women ‘hesitate’ to respond fully. Suksinchai found half of the women had never attended school, half of the women were Christian, 233 women reported working outside of camp, forty percent of women had given birth to four or more children and about half smoked tobacco.

Her results showed that there were significant amounts of miscarriage, probably due to smoking habits, but also conceded the confounding variables of poverty, prolonged under-nourishment, poor sanitation and inadequate health care may well have influenced pregnancy outcomes. Significantly, she found higher levels of ‘miscarriage’ in women who were working outside of camp but did not consider the connection with the women’s need to find paid work and the disruption to income earning potential a birth can bring.
Looking at the global situation

The World Health Organization, UNFPA and other concerned people have documented the vast numbers of women who die or become very ill in childbirth. It is estimated that 500,000 women die every year from preventable problems associated with pregnancy and childbirth, like heavy bleeding (24%), infections (15%), high blood pressure (12%) and obstructed labour (8%). Safe Motherhood programmes were initiated during the 1980s and 1990s which attempted to lower the tragic losses and terrible illnesses that women suffer. There are approximately 19 million unsafe abortions annually, some 2,700,000 taking place in SE Asia (Ahman and Shah 2002).

An estimated 60,000 to 70,000 women die annually from complicated abortions and further hundreds of thousand suffer chronic illness such as reduced fertility, infertility and pelvic pain after poor quality care (Look and Cottingham 2002). About 13% of all maternal death around the world is caused by abortion – usually done by unqualified staff in countries where it is illegal (United Nations Population Fund, Sioncke et al. 2000).

Figure 1 Causes of death in pregnancy - source World Health Organization

The World Health Organization’s terms – ‘safe and unsafe’ abortion add another way of thinking about abortion. Safe abortion generally means the ending of a pregnancy, at the request of the woman by trained health workers who have access to the correct medical
equipment and facilities, usually (but not always) within the laws of the country. Unsafe abortion means the ending of a pregnancy by untrained people or the woman herself, in ways that are likely to cause ill-health and that are often outside the legal framework. The women who die from abortion come from poor, under-resourced countries where abortion is often illegal. Almost no women die in wealthy countries with functioning health services and where women can ask for a legal procedure.

Countries in the region and their abortion laws

Old laws are not necessarily good laws. Many countries that were once colonised by England, France or Holland are examining the law inherited from the colonial master. Many former imperial powers long ago reformed their law so their own women do not have to suffer and die. For example, it is possible to get legal and safe abortion in England. Young Dutch adults are taught how their bodies work and about the risks of sexual activity before they are adults and married, they can have free contraception and abortion is legal - Holland has the lowest recorded abortion rate in the world. While this does not make England or Holland perfect countries it does mean that people can protect themselves against sexual illnesses and unwanted pregnancy if they are assisted.

This figure shows the different abortion laws and government policies in our region. There is a wide diversity in how each country approaches the issue. India, a democratic, secular and largely Hindu nation legalised abortion in the 1970s whereas Nepal only stopped putting women in prison on abortion related crime in 2002 (Tamang, Shrestha et al. 1999; de Bruyn 2002).
Figure 2: Status of abortion in countries in our region.
Refugees or migrant workers?

There are more Burmese in Thailand than anyone can count in part because many of them are undocumented. There are various estimates of more than one million Burmese citizens in Thailand working in construction, farming, factory, entertainment and housemaid type work (Caouette, Kritaya Archanvanitkul et al. 2000).

Their work and living conditions are unsafe, unsanitary and poorly paid (Pim Koetsawang 2001). There is not always a clear distinction between those who are refugees and those who work on the farms or in the factories, as they often come from similar areas and may have mixed experiences of discrimination, prejudice, and human rights abuses (Caouette and Pack 2002). Some Burmese women come to Thailand and work in the entertainment or sex industry (Images Asia 1997) others are escaping the injustice and terror inflicted by the SPDC (Apple 1998) (Shan Human Rights Foundation and Shan Women’s Action Network 2002). Not all Burmese who have experienced a real fear of persecution are processed by the United Nations High Commissioner for Refugees or reside in camps (Human Rights Watch 2004). Some Burmese come to earn money, save it for the future and remit it to their families back home and others are targets due to their ethnicity or religious beliefs (Human Rights Documentation Unit and Burmese Women’s Union 2000; Karen Human Rights Group 2002). Burma now has a documented human rights problem as well as being economically and socially underdeveloped, particularly in relation to Thailand (United Nations Development Program 2002). It is possible for some Burmese to find partial social and monetary security in Thailand but many are not documented as seeking asylum. Moreover Thailand is not a signatory to the 1951 Convention for Refugees but is bound by customary international law as are all nation states.

This is the double bind for Burmese workers, as they leave their country illegally and enter Thailand illegally which places them at risk. This makes wage remittance to families in Burma complicated. Remittances into Burma are not recorded but must be significant. There is no recorded Burmese household income or percentage of Burmese women in the Union of Myanmar workforce recorded by the Asia Center for Migration. Inflation was recorded as 18% in 1999 and there are numerous newspaper references to the limping economy and lack of overseas investors in Burma (Asian Migrant Centre 2002). The CIA
Section (1) Is there a problem?

(Central Intelligence Agency 2003) record a quarter of the Burmese people living in poverty. Indeed significant international sanctions are in place against trade as well as other diplomatic issues (United States Department of State 2003). Obtaining credible and substantiated data from inside Burma is very difficult due to censorship and propaganda. The main point being there is a significant difference in many economic indicators of individual wealth, national economic development and security between Thailand and Burma that induce large numbers of Burmese to seek a better opportunity in Thailand.

More than 50,000 Burmese migrants work in the five agricultural districts in Tak province, a large proportion of them are young women. Thai officials record worrying levels of carcinogenic chemicals in fruit, vegetables and flowers from the region (Aung Su Shin 2003). Nobody knows what affect these chemicals have on fertility or pregnancy and birth outcomes. Burmese women's health has come to the attention of the Ministry of Public Health (Royal Thai Government 2001). Unsafe abortion is a large problem facing irregular migrants within the target geographical area. According to MOPH, abortion rates among the migrant women were 2.4 times higher than among Thai women in 1999. A multi-stage cluster survey among 514 migrant women aged between 15 and 44 years (of whom 309 were married women) conducted by the Ministry Of Public Health in Mae Sot District in 1999, showed that only 53.7% of married women reported using some form of contraception, and 18.7% of women surveyed reported at least one miscarriage. The Ministry of Public Health estimates it costs only 250 Baht at most on average to provide health services to a migrant worker per year. Among many Thai’s and other people there is a recognition for the need for better health outcomes and preventative health care for Burmese people who offer so much to the Thai economy.
Section 2

Defining abortion
Section 2

Defining abortion

Abortion has very specific meanings to different groups of people and so different definitions were used during the phases of the study. While this makes a strict comparative understanding difficult it also brings the complexity and diversity of abortion into the foreground. We will outline the different ideas about what the word abortion means.

Many pregnancies end before babies can live without the support of the mother’s body. Most frequently no cause is found but genetic problems, malnutrition, disease and poisons can cause a pregnancy to end. When a pregnancy ends before the baby can live independently of its mother, it is called abortion. Abortions can occur spontaneously and are termed miscarriage. Alternatively, pregnancy can be ended intentionally and is called induced abortion. In Thailand where there is no access to legal abortion for Burmese, women induce their own abortions in unsafe ways. There is no medical test to tell the difference between the two and health workers rely on the woman to tell them what happened, as well their examination of her body. Sometimes it is not possible to know why or how a pregnancy ended. What is interesting is that everybody has a different idea about what an abortion is.

Mae Tao Clinic

At the Mae Tao Clinic any pregnancy lost before 7 months is called an abortion and is differentiated into standard medical categories. Mae Tao Clinic staff call a miscarriage a ‘spontaneous’ abortion and one that ends intentionally as an ‘induced’ abortion. Sometimes it is not possible to know the cause of an abortion as there is no special test and women are often embarrassed to say the truth. Health workers often define the abortion by its most distinctive feature and so write ‘septic abortion’ meaning one that is infected or ‘incomplete abortion’ meaning that the placenta is still inside the womb.
Thai Public Hospital

The Thai staff defines all pregnancy loss before 5 months as an abortion and then differentiate by the cause. So they call an induced abortion ‘criminal’ if it is performed outside of the Thai legal system. Elective abortion is possible in Thailand to save the woman’s life or in cases proven of rape or incest – so it is still restricted. Any other kind of induced abortion and especially those performed by unqualified people are considered illegal and criminal. They also use the terms ‘spontaneous’ when referring to a natural miscarriage or ‘incomplete’ or ‘threatened’ abortion.

What is significant is the time difference of two months. This has a simple explanation. The Thai medical system is resource-rich compared with the Mae Tao Clinic. In order for a very premature baby to survive it needs a reliable supply of oxygen, electricity, incubators, special medicine and very skilled nursing and medical care. The Mae Tao Clinic has none of these things. If a premature infant is born it is unlikely to survive unless quickly transferred to the Thai health system which is rarely possible. This introduces the idea of ‘viability’ or the ability of the premature baby to live independently from its mother and the placenta.

Women and lay midwives

Interestingly women and lay midwives have their own cultural definitions of ‘viability’ and ‘abortion’ just as bio-medicine does.

Married women during interviews talked about their menstruation being ‘blocked’ for several months and would then take herbal medicines to ‘unblock’ it. It would seem that they were indeed pregnant and had aborted themselves but this was not always defined by them as an induced abortion. The widespread use of blood purifiers or hot medicine in Burma is documented (Population Council and Department of Health Union of Myanmar 2001) and this maybe a culturally approved way to end an unwanted pregnancy. This is similar to Bangladesh where ‘menstrual regulation’ in the early weeks of pregnancy is legally and socially condoned and widely used but not called abortion. Another example of culturally approved abortion is in Hmong women. In Hmong culture children are cherished and large families desired but as women
age and have many children they are ‘allowed’ to used herbal medicine to induce abortion. This herbal medicine is not given to younger women with few children and they do not have access to this information (Pranee Liamputtong 2003). These are traditional ways of defining abortion.

Lay midwives were able to describe the development of the baby, where for several months it is ‘only a blood clot’ and later becomes human-like in the third or fourth month when it moves and looks something like a shrimp. This idea is similar to Western cultures in the past where women defined their own pregnancies at ‘quickening’ sometime around the 18 to 20 weeks when the baby was first felt to move. As technology has progressed people have been able to see the baby with ultrasound equipment or test urine when the menstrual period is only three days late and so people’s awareness and the culture of defining a pregnancy has changed.

This is mentioned to show that abortion and personhood are culturally and historically defined terms and for the sake of this study each group’s definition is considered valid.

These various definitions of early pregnancy loss demonstrate that there are many different understandings of the word abortion. Therefore we need to be aware that when we discuss abortion people may not always share the same meanings.

Conclusions

- In this area there is a variety of definitions of abortion so strict comparison between institutions or people’s experience is not possible.

- Definitions found in ‘classic’ medical textbooks particularly those from countries where induced abortion is legalised as an elective surgical or medical procedure, should be ‘localised’ and taught with the experience and definitions of pregnancy loss found on the border.
Overview of numbers

A quantitative picture is an important element of analysis and Figure 3 gives an overview of patient flows during 2001. This diagram presents the numbers collected from Thai and Burmese health sources and collated retrospectively from hospital records and annual reports as well as the medical record review.

Unfortunately statistics rarely tell the whole story and any attempt to give precise numbers in this area is flawed for several reasons. The size and sex of the population of Burmese living in Tak is unknown due to their irregular immigration movements and therefore the precise number of fertile age women is unknown. Data was collected from only two institutions but there are private practitioners and one private hospital, though it is doubtful that many Burmese could afford to pay for private care. Not all women attend health services for antenatal care, delivery or abortion and so the figures here do not represent the incidence in the population. Not all visits to the public hospital are disaggregated by nationality. Both institutions define abortion differently and at times misdiagnose and a Thai data collection year does not correspond with a Burmese data collection year. Spontaneous and induced abortions are not presented separately in official records and are counted together. Furthermore, recording systems are not perfect and some records are lost or counted incorrectly. Despite this convoluted caveat and until recording systems improve, this is an informed estimate and probably reflects the state of affairs in many resource poor areas of the world where there are large numbers of informal migrants.

There are an estimated 80,000 women of fertile age in the Burmese community and some women experience spontaneous or induced abortions. An unknown proportion of these women reach a health service where they then are recorded as a medical event. The Mae Tao Clinic IPD records 231 women who were admitted for post abortion a care in 2001 and 185 women who attended Mae Tao Clinic for OPD post abortion care and a further 34 who were referred to hospital. The Thai hospital records 360 Thai and Burmese women receiving post abortion care during 2001 and some of these were referred
Figure 3. Overview of numbers in 2001

Mae Tao Clinic

- Inpatient admission for Post Abortion Complications: 231
- Outpatient visits for Post Abortion Complication: 185
- Births in delivery room: 563
- Antenatal care visits to clinic: 5,417
- 34 referrals for PAC care
- Referrals for obstetric care: 180
- Estimated number of Burmese women in the community: 200,000 +

Thai Public Hospital

- Maternal death: 10
- Post abortion complications for Burmese and Thai women: 360
- Babies born to Burmese women: 782
- Babies born to Thai & hilltribe women: 1,434
Section (2) Defining abortion

from refugee camps. Burmese women can come directly from Burma to the Thai hospital, be referred from Mae Tao Clinic or a Thai health station or refer themselves from the local community. As maternal death is a small figure we present pregnant women’s deaths for 2001 and 2002. During these two years 14 women died. None of the women were Thai, two were Hmong hilltribe women and 12 were Burmese.

**Characteristics of women who attend for post abortion care**

The following section presents the findings from the medical record review in the reproductive health outpatient department, an overview of the women referred to the Thai public hospital and more on maternal mortality.

**Age, marital status, type of abortion and living children**

There were 196 women recorded who attended the Mae Tao Clinic for abortion complications in the Reproductive Health Out Patient Department (RH OPD) in 2001. Eleven (6%) records were unable to be processed or recalled due to a mistake in the recording systems. Fifteen women visit RH OPD each month on average which does not change according to season.

The following table shows some of the characteristics of the 185 women who attended RH OPD for complications with a pregnancy loss.
The Mae Tao Clinic health workers diagnose a quarter of all women with an induced abortion and three quarters with a natural abortion.

Ten percent of women are young women and seventeen percent were older women. The youngest girl was 15 years and the oldest woman was 45 years.

Seventy-four women are recorded as married in the medical records but there is no entry for one hundred and eleven women.

Twenty-eight percent of women had five or more pregnancies in their life.

Twenty-seven percent of women had no living children, and ten percent had four or more living children.

Not all records had complete pregnancy and birth information.

Nearly half of the women had experienced a pregnancy loss before.

In the same year 260 women were admitted to in-patient level care at the MTC.

Haemoglobin level was recorded for 132 women and sixty percent recorded a level of 10.7 or less. (Normal is between 11 to 13)

Ten percent of women come directly from Burma for treatment.

---

Table 1
Patient profile from the RH OPD medical record review 2001

Mae Tao Clinic Reproductive Health Out-patients (n=185)

<table>
<thead>
<tr>
<th>Age</th>
<th>20 or younger</th>
<th>21 to 34</th>
<th>35 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>10%</td>
<td>73%</td>
<td>17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status (n=74)</th>
<th>100% women recorded as married</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of abortion</td>
<td>Induced</td>
</tr>
<tr>
<td></td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancies (n=172)</th>
<th>1</th>
<th>2 to 4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19%</td>
<td>54%</td>
<td>27%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living children (n=143)</th>
<th>None</th>
<th>3 or less</th>
<th>4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27%</td>
<td>41%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous abortion (n=143)</th>
<th>43%</th>
</tr>
</thead>
</table>
Section (2) Defining abortion

- Health workers generally did not record information like ethnicity, education, employment, religion, domestic violence, sex-work or rape in the medical records of women presenting with abortion.

- Medical records give only partial insight into the complexity of all types of abortion and those women experiencing a pregnancy loss.

**Length of pregnancy in relation to pregnancy loss**

Most pregnancies ended in the first three months of pregnancy according to the medical records. Natural abortions are more likely to occur in the fourth, eighth, twelfth and sixteenth weeks of pregnancy and this is the case found in the medical records. More women came at these times in their pregnancies with abortions/ miscarriages. In the 185 recorded pregnancies that threatened abortion or ended, 118 (64%) women aborted in the first three months of pregnancy, 46 (25%) in the middle three months and one woman’s pregnancy ended in the 25th week (seventh month). In 21 cases the gestation was not recorded.

**Number of visits to OPD**

Many abortions can be managed safely on an outpatient basis. There were 320 visits recorded for this group of 185 women. Forty-five percent made one visit, thirty-five percent two visits and twenty percent of women came three or more times for the same case of abortion. The health workers often requested the women to return to the Mae Tao Clinic but no further visit was recorded. This means that women often were not provided with follow-up care or educational information such as family planning counseling. Health workers and women require more time together for quality post abortion care.
Women with a diagnosed induced abortion

During 2001 fifty women were diagnosed with an induced abortion from the OPD medical records. These women did not differ from the other women in any particular way. Seven were teenagers and eight were 35 years or older. Thirteen women (27%) had no living children and twenty-two (45%) women had between 1 to 3 children and four women had 4 or more children. One woman had seven living children. (In ten cases there was no record of living children) Twenty-three (46%) women said they had never had an abortion of any kind before and 18 (36%) had had one or more previous abortions. (In nine cases there was no record) Just over half of this group made more than one visit for the same case of abortion. Health workers recorded the use of international and Burmese medicines, massages, visits to traditional midwives (let thay), sticks and accident type stories to end the pregnancy and this is discussed in more detail later. In half of the case notes there was no record of the relationship with the man. In 60% of cases there was no information regarding the provision of post abortion contraception. This group of women did not appear to differ significantly from the other women other than they had ended their own pregnancy.

Burmese women referred to hospital level care for complications of abortion

As Mae Tao Clinic does not function at a specialist-hospital level, women who are very unwell or who require surgery need to be referred to specialised gynaecology and obstetric care. Thirty-nine women were referred to the local Thai public hospital from mid March to December 2001 and their medical records were reviewed. Five medical records were excluded from review as they were ectopic pregnancies or other complications of early pregnancy that present like abortion such as a molar pregnancy or pelvic inflammatory disease.
Table 2.
Patient profile of women referred to the Mae Sot Public Hospital for post abortion complications

Thai Public Hospital Referred patients to In-patient care (n=34)

<table>
<thead>
<tr>
<th>Age</th>
<th>20 or younger</th>
<th>21 to 34</th>
<th>35 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>23</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Transfusion</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dilatation &amp; curette</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancies</th>
<th>1 2 to 4</th>
<th>5 or more</th>
<th>Incomplete history</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>316</td>
<td>9</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Malaria positive</th>
<th>Yes</th>
<th>No</th>
<th>Not checked</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>23</td>
<td>11</td>
</tr>
</tbody>
</table>

| Total Hospital bill | 104,205 Baht |

- Eight women were over 35 years of age and three under 20 years of age.
- One woman had been pregnant fourteen times and given birth nine times.
- Nine women had experienced five or more pregnancies.
- One woman had two dilation and curette procedures and six required blood transfusions.
- None appear to have malaria.
- One woman died. She was 5 to 6 months pregnant at the time of the abortion. She died after three days of intensive treatment at Mae Sot Hospital with a severe septic shock.
- Three women were sterilised and no other contraceptive method was given to the other women.
- The total cost of hospital care for 34 women with abortion complications was 104,205 Baht or 3,065 Baht on average per case of abortion or pelvic infection, which ranged from 550 Baht to 18,695 Baht.
Maternal death

Most women survive the abortion experience but a few die. During 2001 to 2002 fourteen women died whilst pregnant in this area of Tak. Two appear to have died because of induced abortion. None of the dead women were Thai nationals. Most of the women were Burmese and a couple were hilltribe women. By comparison 19 women are recorded as maternal mortality deaths due to abortion on average each year on average in the whole of Thailand which has a population of 61 million people. In 1994, 104 women died from pregnancy related reasons per year in the whole Kingdom and 14 were abortion related (Ministry of Public Health 1997). The following graph shows a breakdown of the causes of death of the pregnant women.

Figure 4. Causes of maternal death in the Thai Public Hospital 2001 to 2002 - total 14 women

Malaria (22%) and unsafe abortion (22%) are the major killers of pregnant women in this area, closely followed by obstructed labour (14%) and haemorrhage (14%). Many of these causes are preventable. The impression from the medical notes is that the Thai hospital staff had given all possible medical treatment to these women – some died in the intensive care unit. Multiple medications, intensive observations, oxygen, operations, blood transfusions and so forth were all charted and resuscitation attempts documented. Their high hospital bills testify also the considerable effort put into their health care. Most women died very shortly after admission into the hospital and were seriously
ill if not moribund on admission. In essence they came too late and were already beyond the ability of bio-medicine to save their lives.

Here we can begin to understand the significant difference between the health outcomes due to nationality. There are several possible explanations why the women arrived at hospital in a late stage of sickness. Firstly, movement for Burmese women with no documents is restricted and the fear of arrest contributes to late attendance for health care, secondly referral systems between Thai and Burmese health workers are not well integrated and thirdly, there is not always an understanding at the community level that some pregnancies are a risk for women's health.

While the deaths are recorded at the local level, the deaths of Burmese women are not recorded at a national level in Thailand. There is no committee to review and discuss the possible prevention of death in healthy pregnant women. In this site where Thais, foreign humanitarian agencies and irregular health facilities like Mae Tao Clinic co-exist, it can be difficult to ask people to sit together. The World Health Organization (Bangkok) does coordinate cross border and between institutions on issues like malaria and TB at a provincial level, so why not on maternal deaths? The Myanmar Department of Health probably does not know that Burmese women die in Thailand, as they do not appear on official records. These women are forgotten, they are the missing ones.

Characteristics of women interviewed in IPD admitted for PAC

Forty-three women agreed to give an interview while they were recovering from their abortion experience in the Mae Tao Clinic or the Thai hospital. Seven women declined to be interviewed or were not able to understand consent issues. There is no census data of the Burmese community outside of camps and so it is unknown how representative this sample is but when compared with the 185 OPD PAC medical records it is similar.
Table 3
Patient profile of 43 women with post abortion complications

*Intervews with women with post abortion complications (n=43)*

<table>
<thead>
<tr>
<th>Age</th>
<th>20 or younger</th>
<th>21 to 34</th>
<th>35 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>28</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Married</th>
<th>Separated</th>
<th>Widow</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>40</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of abortion</th>
<th>Induced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pregnancies</th>
<th>1 2 to 4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>621</td>
<td>16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living children</th>
<th>None</th>
<th>3 or less</th>
<th>4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>28</td>
<td>7</td>
</tr>
</tbody>
</table>

- The youngest women interviewed were 18 and the oldest 41 years.
- The average age of marriage was 21 years and most women were in a married or long-term relationship.
- More than a third of the women had induced their abortion on their own or with the help of an abortionist and two thirds had natural abortions.
- A quarter of the women had experienced five or more pregnancies—this is a health risk in itself.
- The majority of women had children already and only eight had no living children.
- Most women are prepared to talk about their pregnancy loss experience if provided with privacy, confidentiality and gender sensitivity.
Other social characteristics – ethnicity, religion, education and employment

While the medical records did not record social information, during interviews women were asked about their ethnic identity, religion, education, work and the nature of the relationship with the father of the baby. The following table presents this information.

Table 4 Social characteristics of 43 women with post abortion complications

Interviews with women with post abortion complications (n=43)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Karen</th>
<th>Burman</th>
<th>Mon</th>
<th>Muslim</th>
<th>Rakine</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
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- Women defined their own ethnic identity and some stated they had parents from different Burmese ethnic groups showing that ethnicity is not necessarily a discrete category.
- Burmese was the commonest language spoken and widely understood followed by Sgaw Karen.
- About a quarter of the women interviewed could not read basic Burmese or Karen languages and the rest only had three to four years of school.
- The vast majority of women interviewed were Buddhists but most religious beliefs were represented.
- Most of the women were in paid employment and contributed to the family income.
- Six women disclosed domestic violence in their relationship.
- Women came from a diversity of ethnic and religious backgrounds and the majority were in paid employment and had living children to support at the time of the abortion.
The Burmese community living outside the camps in Thailand is generally regarded as migrant workers, transient in nature, who quickly return to Burma. This figure shows that a significant group choose to stay for long periods of time in Thailand.

**Figure 5 Time in Thailand of 43 women who experienced a post abortion complication**

- The majority of the women were long-term residents of Thailand with three years or more in Thailand.
- Nine women were recent arrivals under one year.
- Most of the women lived in the town or on a farm in a rural area.
- Two women came directly from Burma for their care.

Most women had lived in Thailand for over two years suggesting that the population is more stable than is normally thought. They contribute to the Thai economy often for several years.
The interviews demonstrated that most women were in paid employment or were hoping to find a job. They did skilled and unskilled work such as sorting and packing clothes in factories, working machines that made clothes, gem polishing, farming, processing vegetables and flowers for markets, servants for Thai people, construction work and small scale business. Their wages were very low and often lower than men’s for the same work. Some women worked as unpaid housewives but often took on laundry work to supplement their husband’s income. In this study only nine women had a work permit and they reported it cost 4,500 Baht to purchase as well as pay for the health care checks. Women wanting to gain a work permit must test negative for pregnancy before they are issued with a valid work permit (Bhimiprabhas 2001; Naridsa Suksanan 2002). Thai employers were instrumental in arranging the work permits for their employees. Twelve women out of forty-three reported working in the factories around Mae Sot. Women reported working hard, long hours with little rest. A Karen woman with an induced abortion describes her work and pay.

My husband and I came here to work in the factory because we couldn’t make ends meet in Burma. We have been here 8 months. When we have a little bit of money we will go back but I don’t know when that will be. We work at the looms in the sweater factory. We get paid by piece work. We can earn 2,000 Baht each per month.

And another woman who describes herself as Mon with no children and a miscarriage is in a similar situation.

I earn 2,000 Baht per month and my husband earns a little more than me. I got married here. Working in the factory does not affect my health but it does make me very tired. I work at the knitting machine and it makes my muscles ache. When we have a big order we have to work fast and for very long hours.

And this woman who had a stick abortion, whose husband hopes to save money for a business in Burma said,

In Burma business is bad so I came here. I did any job possible in Burma. Most of the time I worked in restaurants, I got 170 Kyat per day. Later the boss paid me 200 Kyat and fed me food because he...
Section (2) Defining abortion

"Women work in sales, farming, tailoring, manufacturing as well as caring for their families"
knew things were bad. In Thailand I work in a factory and I can earn 1,000 Baht per month if there are lots of clothes to sew. If the orders are small I can only make 900 Baht. My husband earns more than me. He earns 2,000 to 3,000 Baht because he is experienced and quick. I am new and slower.

With a variable income it is difficult to plan for the future.

A Burman woman said, ‘We’ve only been here eight months and we work on a farm. We are both paid 80 Baht per day. It is enough. I send a little money home for my children in Burma. We think we will stay for one more year here.’ This means this couple together earn 4,480 Baht per month. And a similar case, ‘My husband and I work as daily workers and we get about 70 Baht per day. This type of work doesn’t seem to affect my health. I have no contact with pesticide but my husband sprays pesticide on the farm.’ And another Burman woman was four months pregnant when she was employed on this farm, ‘I have been here only ten days and some of that was in hospital. I only worked for two days on the farm and I got 70 Baht and my husband got 80 Baht.’ A wife’s income is necessary for family survival.

These statements show the low wages given to Burmese workers in Thailand and that most of the women with induced abortion were working wives. Their income was frequently irregular and not guaranteed which increased their insecurity. A minority of women had a valid work permit. In addition, women often earn less than men for similar work. Women often contributed half of the monthly income and this was significant in their decision to end the pregnancy when they could not work.
Worry, fear and insecurity

Women expressed worry and fear while in Thailand. A 19 year old woman with an induced abortion said, ‘I am very scared about living in somebody else’s country but I have to stay here to live.’ A Karen woman said ‘I feel safe most of the time but I do feel worried that the police will arrest me even though I have a card.’ She knits sweaters in the factory. A Karen woman with a miscarriage said that her work permit card provided some relief for her. ‘I did feel anxious in Thailand at the beginning when the police watch us. Now I have a work permit card so I do feel safer. If I stay with my family in Burma I feel safe but the government comes and asks for porters and money.’ And the Burman woman recently arrived from Rangoon noticed the tension. ‘I am not happy being in Thailand and I don’t know what will happen if I go out and about. I hear the people talking about the police. I can see that they are very scared of the police. I think I will have to be very careful and learn about Thailand.’ Fear and worry were daily realities and influenced how women moved in the community.
People had lived in Thailand for varying amounts of time as already stated but most dreamed of going home to Burma, often with their economic goals met, or when the socio-political situation in Burma improved. Very few people seem concerned with any immigration regulations that Thailand may devise and only commented that the work permit, while expensive, was worthwhile to have for the perceived security and safety if offered. Very few people said they did not want to go back.

This Mon woman with an induced abortion has an economic goal.

"I came here because the economic situation was better in Thailand. I came here with my friends and I got married while I was here. I thought if I can save some money I will go back to Burma."

And this Karen woman,

"I didn’t have a job or a house in Burma. I had to live with my parents and I didn’t like that. I came to Mae Sot in 1995. If the economics and politics in Burma doesn’t change I won’t go back."

And a different Karen woman living in town said,

"I thought that if the situation in Burma improves I would like to go home. I don’t want to live here forever. I lived here nearly 18 years. I have visited my family in Burma several times."

In this study we interviewed the wives’ husbands to get a deeper understanding. These two men are running from their past. This father of three with 8 years of schooling recounts his situation.

"Then the 1988 uprising happened and most of the Burmese agreed with having a democratic country. We voted to get a democratic system and a party into power. As I was a soldier I voted. If you go to school you understand the meaning of..."
democracy so I voted for democracy. At the moment I cannot go back to Burma because everyone knows I was a soldier. Deserters get shot."

And finally this husband with ten years of schooling who now works in a factory with his wife who has had two induced abortions.

"This situation is bad in Burma and we were poor so that is why we came here. After we were married we didn’t have any money and our parents couldn’t afford to look after us, so we came to Thailand to get work. When I lived in Burma I sold things but money was tight. My parents did support us to sell things. I spent a lot of money and I didn’t save any. I cannot go back to Burma."

Women are pressured by the social-political situation in Thailand and Burma to be economically productive rather than reproductive.

**Conclusions**

- The provision of life saving post abortion care at the hospital level uses many health resources and public health measures should be implemented to prevent unwanted pregnancies and unsafe abortions.

- Health workers should be encouraged to record a full social and gynae/obstetric history for each woman, unless it is apparent from the sum of all past entries.

- Regular random reviews of health records should continue for monitoring and evaluation purposes.

- Health workers in the Mae Tao Clinic appeared to need more time with patients in order to provide complete post abortion care in the OPD.

- Women, especially those at higher risk, such as possible induced abortion, history of repeat abortions, very young or five or more pregnancies should be admitted overnight for evaluation, education and counseling.
• Out reach programmes with the assistance of Thai public health officials should be implemented.

• Temporary contraceptive methods should be offered to women while they are in-patients.

• Burmese women’s death’s are reviewed at a local level but should be recorded at the national level in Thailand.

• Health statistics and costs should be supplied to the Union of Myanmar Department of Health and they should be asked to contribute to Burmese women’s health in Thailand.

• All public health information should be designed at a primary school level of understanding.

• Health education and information should be given in Burman as well as Sgaw Karen - or other appropriate common languages.

• Public health education programmes would be useful and effective in this population as they are more stable than assumed.
Section 3

Ending a pregnancy

(Kathy Pan, pummelling and sticks)
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Section 3

Ending a pregnancy

(Kathy Pan, pummelling and sticks)

Women use oral and injectable medicines, both international and indigenous as well as certain food and drinks found in their kitchens. Women often chose medicines and foods they considered to be ‘hot’ according to cultural understanding.

Women also employed certain actions and vigorous manipulations to dislodge the foetus. Friends, husbands and lay midwives (*let thay*) assisted in the provision of advice, money, transport and support for the abortion. Lay midwives offered women abortion services for a fee that involved pummelling and the insertion of vegetable material, usually wooden sticks or leaf stems into the uterus. Obviously these methods have the potential to be harmful and at times life threatening to the woman.

If the attempted abortion fails, they also have the potential to cause disability to a developing foetus. Many abortion attempts are probably successful and not all end in disastrous health consequences needing health care.
Blocked menstruation and Kathy Pan

Kathy Pan raises strong feelings in the community. Is it a pain killer? Does it unblock menstruation? It is a contraceptive or abortifacient? From some women’s interviews it is clear they appear to use it like a contraceptive. Here a 29 year old married Burman woman who had three pregnancies and two children describes some side effects from modern methods of contraception and her preference for Kathy Pan.

“My husband told me to stop taking them [oral pills and Depo] but I continued. Then he blamed me when I complained of pains. The only thing I can take regularly with no problems is Kathy Pan. I take one sachet every ten days.”

For this woman there are no discernable side-effects from Kathy Pan but some health workers report that it causes perspiration and red eyes. Other women who described taking large quantities over short periods of time said they felt ‘dizzy’. This 31 year old Burman woman who has lived in Thailand for five years and always had regular menstruation, only took Kathy Pan after her period was ten days late, after she married.
"This is my first pregnancy. I wasn’t sure if I was pregnant or not – I only knew that my period was ten days late. I took Kathy Pan, 10 tablets per day for two days. I took four packets or 20 tablets in total. The next day I bled a little. There was no pain. I never used it when I was single. My periods are normally regular. They always come at the same time of the month."

This is not contraception but menstrual regulation or an early abortion. Kathy Pan is linked with the idea of abortion both for women and in the wider community.

From lists generated with women in the community, health workers and *let thay*, on the indications and effects of Kathy Pan are interesting. In answer to the question why take Kathy Pan? Women responded with the following list:

- contraception, child spacing and family planning
- irregular periods
- to clean the blood
- to regulate periods
- to make abortion
- family planning for married women
- protection from gynaecological diseases
- for use in menopause
- as emergency contraception
- pain relief for periods
- to moisturise skin
- to produce more breast milk
- to get old blood out after delivery or abortion
- to treat malaria
- to treat dengue fever
- if the body temperature is too low
- for cough
- for distended stomach and diarrhoea

Skidmore (Skidmore 2002) describes Burmese women’s understanding of blood circulation which is conceptualised like a river flowing though the woman’s body and if blocked can congeal in her stomach and rise to her head causing palpitations, dizziness, headaches, madness, shock and ultimately death. *Thway say* or ‘hot’ medicine is useful to assist the flow of blood or to bring down the blood. The Burmese health workers at the Mae Tao Clinic are aware of
Working Our Way Back to Home

Section (3) Ending a pregnancy

Kathy Pan and other ‘hot’ methods used to induce abortions. The OPD medical record review records 20 cases of ingesting either Kathy Pan or another type of *thway say* and 31 cases where the woman disclosed visiting the *let thay*.1 (Total number of induced abortions = 50)

Kathy Pan is very accessible to women. It is found in local shops and the market place. It is also very affordable. It comes in pressed tablet form or capsules. The white box with capsules is sold as specifically for abortion but the ingredients appear to be identical. Samina, the Muslim shopkeeper talks about the Kathy Pan she sells in her shop.

"Kathy Pan is popular. I can sell three large packets every month in this neighbourhood. All the women take it, single girls, unmarried women as well as the married women – they all take it."

A 35 year old Burman woman with an induced abortion describes Kathy Pan well.

"I didn’t take Kathy Pan before the bleeding. I took it after the bleeding started. It is for bad blood, it helps to clean out the blood. I am scared because some people told me that Kathy Pan is for abortions. I thought the baby didn’t want to stay with me and I had bad blood. Most women from Burma take it during their periods to clean the blood. You can see it on TV- there is a famous actress talking about it. Kathy Pan makes you more beautiful. Two packets of Kathy Pan costs just 5 Baht. I don’t know how much a big box costs. I never took it before. I never had pain like this before. There are 5 pills per sachet, you mix it with water and it smells quite bad."

Kathy Pan is mass produced for international consumption by Myat Chan-Than Medical Hall, San Chuang Township in Rangoon (Myat Chan-Tha Medical Hall 2003). Myat Chan-Than informs the purchaser that Kathy Pan is made of ‘rare, costly herbs’. They make no secret about the ingredients which include Indian redwood tree, black pepper, nutmeg, cloves, sandalwood and camphor. Kathy Pan contains a leaflet inside about how to take it in several languages; Burmese, Thai, Chinese, Hindi and English. The instructions are specific,
4. If the menstrual flow is overdue for three weeks or one month, take 12 capsules with water for three successive days. (This medicine can be taken with alcoholic drinks.)

5. To those married women who want to stay away from pregnancy, take 3 capsules with water on the 10th day after menstruation and take 3 capsules after an interval of another 10 days, and take 6 capsules on the day before the next menstrual period is due. (Stop taking the medicine when the user wants to get pregnant.)

This type of menstrual regulation or early abortion is used around the world and a very similar recipe called Labrik which contains ginger and cloves, is taken by women in Morocco to regulate their periods (Gary Martin 2004).

(Caouette, Kritaya Archanvanitkul et al. 2000) reports that 34% to 45% of attempted abortions were successful in her study of Burmese reproductive health in Thailand. There have been no published medical trials to test the efficacy or side effects of Kathy Pan, so it is difficult to advise women and health practitioners on its correct usage and dose.

The ambiguous nature of thway say is useful for Burmese women to regulate their own menstrual cycle without necessarily being accused of abortion. It is described by some women as traditional and others as modern. It is a hybrid medicine.

The table shows the various methods used by women who were interviewed while inpatients in this study.
Table 5

Reported methods used by women to end a pregnancy or unblock menstruation

Reported methods used by Burmese women to end a pregnancy or unblock menstruation

**Oral medicine**

**International**

Injections – ‘Menstogen’, oxytocics such as ergot, Syntocinon,

**Herbal or local preparations considered to be ‘hot’ (thway say)**

- Kathy Pan
- Nit kwet say (Two cups medicine)
- Kwet de say
- Singla thway say

**Food or drink**

- Alcohol
- Dog meat
- Ginger & sugarcane
- Pepper and hot water

**Action & Touch**

- Kicking with heels of feet into pelvic area
- Standing on pelvis/abdomen
- Jabbing with elbow into pelvic area
- Vigorous pinching and pulling at womb through abdomen
- Falling down
- Fighting with husband, being kicked or punched by him in back or abdomen
- The application of hot stones on abdomen to ‘melt’ the foetus

**Insertion of objects into the genitals**

- Twigs from trees
- Stems of leaves
- Chicken feather quills
- Cotton buds
- Bamboo shard
Pummelling and Sticks

Vigorous physical activity and ‘massage’ are also common abortion methods. Let thay provide pummelling and stick abortions and usually most women can find a let thay in their neighbourhood who will offer these services. Women’s medical records note histories of accidental falling, tripping and slipping. Early pregnancy loss is also attributed to carrying heavy loads and working hard.

Most health workers feel that the women’s stories of unlikely accidents and too vigorous bicycle riding are fabricated. In the case note review, there were 31 records of women who visited the let thay for either massage and or stick abortions. Women, health workers and let thay gave accounts of vigorous physical actions glossed as massage abortions. Mu Mu, a junior health worker at the Mae Tao Clinic tells about her experience of abortion methods.

"I think there are more abortions than births, especially in Thailand. The women do it by themselves in many ways. They jump up and down, and fall down roughly on the floor. Other times they go to the let thay and she does massage and sometimes kicks the woman’s abdomen."

Mu Mu’s description of violent manipulations to end the pregnancy is found in other accounts. The non-government organisation transcript of sex workers accounts is graphic,

"I was trying to have an abortion. I had traditional medicine and massage but I did not abort. I asked my friend to stand on my stomach but I still didn’t abort and I had to deliver this baby."

These types of physical manipulations are more than a simple pinching massage as described by Whittaker (Whittaker 2002) – this is pummelling, vigorous enough to displace a well developed implanted foetuses and shear off placentae. They are painful and physically traumatic. Another external technique described by Karen let thay is to ‘melt’ the foetus whereby a hot stone is placed on the abdomen. Often methods are combined. Here a 19 year old Karen house-maid,
who earns 1,000 Baht per month, describes her massage-stick abortion. Her Burmese ‘husband’ left her a few months prior.

"I went to see the apwagee (old woman). She is about 50 years old. She felt my stomach, she said, ‘You are pregnant but only two months.’ She put the stem of a flower inside me. Apwagee said if there was any pain to call her and she would come. I paid her 900 Baht because she told me she would fix it. When she did the massage it hurt and ached a lot."

Two days later she returned to apwagee who tried to pull the foetus out with her hands. At this point the young women, in extreme pain, returned to her Thai employer who took her to the local hospital where she was admitted for three days, had a D&C and borrowed 1,400 Baht from her boss to pay her hospital bill.

Abortion sticks made from leaf stems - Mae Sot 2002

O Htoo Kler a senior health worker in the IPD reproductive health department at the Mae Tao Clinic has a collection of abortion sticks. They are used as a teaching aid for women and junior health workers. It is a motley collection of old sticks, cotton buds and pieces of leaf matter. She has managed every type of abortion. She has informed and clear opinions about her patients. We asked her if she was ever shocked by the cases she saw.

"One special case shocked me. One woman had been to the let thay who put a chicken quill inside her. This did not work the first time so she returned twice more. She only bled a little afterwards. The let thay did not tell her what she
was doing so this woman did not understand that the let thay was putting a chicken feather in her. Then the woman came to me and I examined her. She had a high fever and she was two months pregnant. I was shocked when I saw it. ‘I said do you know what is inside you?’ The woman said no. I showed her the feather. I was scared to think what would have happened to her if her womb had been perforated. I felt very sorry for this woman that she did not understand what had happened. This woman was very poor and could not afford to care for a baby. This woman told me that this was the method that this let thay did to everyone. I felt so worried for these women."

The women corroborated the stick abortion method. These sex-workers were aware of the stick technique.

"She put a leaf stem soaked in soapy water into my womb and she told me that if it works or not that was not her problem. She told me that I had to look after myself. She took 400 Baht from me and told me that it would abort. This is my third pregnancy. I have never done abortion before this."

And another woman,

"They put two cotton buds into my womb and they wanted me to stay in the let thay’s house for one night. I had the stick in my womb all night but the baby did not come out easily. So I went to an Islamic let thay and she took out my baby piece by piece. I did not have to pay anything because we were friends. That was my first abortion."

The two say-yo (medicine sticks sometimes from the tobacco leaf - Burmese) that O Htoo Kler demonstrates measure 8cm and 9.75cm long, between 0.5 to 0.25 cm wide and have been bent into a V shape by the abortionist. She believes they are from the kapok tree (Ho Htoo – Karen). They are round wooden sticks, light in colour and density, and would probably absorb moisture to dilate and also irritate the cervix. They would cause cramping, and a fresh blood loss and eventually infection, with fever and malodorous vaginal discharge. The risk of perforation to the uterus, bladder or bowel is evident.
Sticks are effective and very unsafe and the most serious complications seen in this study were caused by stick abortions. The following case of Ma Nwe Ni shows the determination and desperation involved in a stick abortion.

The first time we saw Ma Nwi Nee she was curled in a ball on a hard bed in the Mae Tao Clinic crying to herself in pain. She was so distressed we did not interview her. She had a lack of progress which manifested as high fever and extreme pelvic pain and she was referred to the Thai hospital. We interviewed her on her seventh day in the hospital. Her chart shows that she is taking a cocktail of antibiotics; Ampicillin, Metronidazole and Gentamycin. She has an intravenous line in her arm. Her haemoglobin is 8.7 (normal 11 to 13) and she weighs 42kg. She had a tetanus vaccination and the ultrasound shows a foreign body in her uterus and marked inflammation in her fallopian tubes with bilateral 10cm and 15 cm abscesses.

Ma Nwi Nee is very pale and weak but she smiles. She is 26 years old, married and works in a factory earning 85 Baht per day. We tell her we saw her come into the Mae Tao Clinic and we are happy she is recovering. She tells about her abortion,

"I crossed over the river and went to the Burmese side with my friends. I went to the abortionist (jay zar let thay). She doesn’t do deliveries – if you give her money she will do an abortion. She is 30 years old and she seems a very nice"
woman. I asked her how much should I pay? It was 5,000 Kyats (350 Baht). I was only one month and ten days pregnant. She put her fingers inside my vagina. She didn’t wear gloves but she did wash her hands. She put say-yo (stick) 6cm into me. It seemed like she was a clean woman. This is what she did. She put the stick in with one hand and pushed my womb down with the other hand to meet it. I heard something inside pop, but it did not hurt. Some blood did come out. When she took her fingers out there was some blood on them. I started to bleed but in a stop-start way. I stayed in her house for four days and each day she would change the sticks. Some days she would put two sticks inside me in one day. When I started to bleed she massaged me on the right side. She kept her fingers on the outside of my pelvic area and she pushed and pushed. She massaged my back too. It really hurt then. After four days I came back to Thailand to get my salary and see my husband. During the night the pain was very bad and I couldn’t stand it so my husband took me to Mae Tao Clinic.

She shows her abdominal wound, just above her pubic hair, a 15cm incision that is open at one end draining clear fluid. Ma Nwi Nee’s account is interesting in that she travelled to Burma and back into Thailand while the border was closed. Most women found their let thay in the town or close to where they lived in Thailand. Secondly, the process of the stick abortion extended over a four day period and involved several insertions and repeated pummelling. Ma Nwe Ni’s stamina to endure four days of this type of treatment shows the determination to end her pregnancy. Ma Nwe Ni did recover and was discharged to the care of Mae Tao Clinic for convalescence. The last time we saw her and her husband, they were discussing a tubal ligation. It is doubtful that she will ever conceive again but nobody had told the young couple that future pregnancies were very unlikely.

In summary, women often began their abortion attempts by taking accessible thway say such as pepper and water or ginger and sugar cane, often with alcohol added, when they notice their delayed menstruation. The market and local shops are a ready source of commercially manufactured thway say products. Kathy Pan is one example of targeted and sophisticated marketing by the domestic pharmaceutical industry in Burma, where pro-natal policies and an under-funded health system do not provide universal family planning.
services. *Thway say* is relatively cheap and is surrounded by ambiguity which means it can be consumed without personal or social acknowledgement of abortion and so maintain personal and spiritual integrity. Women seek out *let thay* from their local community through social networks to assist them to abort, but women will also go to great trouble to find a *let thay*. According to the women, *let thay* charge money for their services, and the price increases with gestation. Men helped with money for the *let thay* and transportation. Both women and *let thay* were believed that abortion was not socially acceptable. Some knew that it was also illegal. Women would sometimes make several visits to a *let thay* or even stay for a period of days with her while the abortion procedure occurred. Very few women inserted objects by themselves and there was only one account of a woman using a piece of bamboo to abort by herself. A few women attempted to pummel their own lower abdomen or ask others to stand on or kick them in the pelvic region. As all of the women who told their abortion story were recruited from a hospital environment, most had suffered complications such as extreme pain, haemorrhage, infection and genito-pelvic trauma. Pummelling and the insertion of sticks were often effective abortion methods but dangerous. This is probably not the case with all self-induced abortions and perhaps many women are able to 'bring down the blood' in the privacy of their own homes without experiencing complications. Self-medication is common and similar to other documented health seeking behaviour but particularly so where privacy and personal autonomy must be maintained. Early abortion or menstrual regulation may well be possible with hot medicine as it is very widely accepted and recommended by Burmese women.

**Recommendations**

- Women need to be informed of the different risks involved in unsafe abortion techniques.
- Lay midwives should be taught about unsafe abortion and its consequences as well as modern methods of family planning.
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(Why end the pregnancy?)
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Section 4
Bad mothers and flawed women
(Why end the pregnancy?)

We have explained how women end their pregnancies and in many cases they are determined and use desperate measures. The next question is why? What would make a woman so desperate?

One simple explanation is to say that these women are flawed women or bad mothers. Could it be true that Burmese women are simply bad people and unsound mothers or are there other explanations?

We present data from interviews with Burmese health workers and community workers, let thay, husbands and the 18 women out of 43 interviewed who ended their own pregnancies. We also refer to the medical record review. Our findings highlight many social determinants in health outcomes for women that show a complex interaction of circumstances which lead to induced abortion. While at the individual level women are limiting their fertility, the very few options available to them and their social circumstances, influence their decision to induce the abortion.
"Weak" women

Specific times and places often produce illness patterns that are unique or cultural artefacts. This does not mean they are not real lived experiences for people, just that reality changes over time and place. A Western example is ‘hysteria’ which was a form of nervousness found in rich women in Europe about one hundred years ago. It is not seen anymore and people explain this by saying that now women are not confined, can move around socially and physically, therefore they have no need to show their distress in this form. At the time it was taken very seriously and medical practitioners treated it as an illness. Not until later did people realise that it was Western culture that made these women ill.

Related culture specific illnesses like ‘nervoso’ are seen in Spanish speaking communities. Burmese culture has something similar called ‘weakness’ (aah neh). There were 167 visits to RH OPD during 2001 where women were diagnosed with ‘weakness’ by the Burmese health workers.

Naw Paw a senior health worker in the RH OPD describes the symptoms of this illness.

“The woman is dizzy, she has poor nutrition, she has cold hands and feet, she worries a lot. We do an examination. Sometimes there is anaemia but not always. We give her health education about nutrition, maybe multivitamins or ferrous sulphate. We say ‘don’t think so much’ and we talk about meditation; something like counselling for her. A typical patient would be a woman who has had a lot of children, may be more than four. She would come and say, ‘Oh my goodness my period doesn’t come, may be I am pregnant again.’ Also those who are breastfeeding. The women who talk about food, family and money worries they get weakness.”

‘Weakness’ is characterised by a combination of physical, mental and social symptoms but not all may be present in the same patient. This is not a moral weakness. Men do not get weakness like women do, maybe only if they worry about their job security or if they have to
work very hard. Children never get weakness, except those poorly nourished.

Skidmore (Skidmore 2002) describes *thwe aah neh* of the blood which is often called anaemia and can also be linked to irregular menstruation or amenorrhea. Certainly many of the women who come to the RH OPD are measurably anaemic but ‘weakness’ is more than low haemoglobin levels. Skidmore (ibid) and Nichter (1981) note that weakness is also an idiom of distress. We note in this study that some women who had induced their abortion had been diagnosed with an earlier case of weakness and talked about ending their pregnancy in terms of *aah neh* or weakness.

**Reasons for ending the pregnancy**

Many health workers were certain why women end their pregnancies. Naw Paw in RH OPD lists them off.

"Poverty, difficult jobs, lack of knowledge about family planning; all influence abortion. People are unable to think well due to the political situation. Some husbands do not take care of their families, some women are abused and others just have many family problems. Some couples live together without marrying but they still get pregnant. Young women at school get pregnant and they have abortions. Sometimes the parents don’t agree with the partner choice and if they are already pregnant and not married this can be a cause of abortion."

Naw Paw’s colleague in the RH IPD, O Htoo Kler is just as convinced.

"I believe most Burmese people’s economic situation is not good and that’s the main reason why they abort the pregnancies. Others don’t understand the consequences of abortion but some do. Some women really understand family planning but it is impossible for them to come to us due to security issues or other things that get in the way. Other women take Depo but they don’t follow the dates so they forget. Young women fall pregnant with their lovers due to inexperience. Some men have many wives, one in Burma
Section (4) Bad mothers and flawed women

and one here, and this causes problems… Every time I see a woman with an abortion I get upset with the Burmese government. I directly blame them for reducing the economic standard so low.”

The social determinants of health and wellbeing for women such as access to family planning services and an economy that can support families are important policy decisions. The Burmese health workers, living outside of the military dictatorship are relatively free to voice their political opinions and are adamant women’s health is directly related to the social-political situation. O Htoo Kler continues,

"I remember one case where a mother came to me and she was three months pregnant and she told me the truth about inducing her abortion. Her second husband had sex with her daughter and she was now six months pregnant. She knew that it was too late for her daughter to have an abortion so she had one. She was very ill and I took her to Mae Sot Hospital. I heard this story twice now – the other one was a husband who had sex with both sisters. These kinds of men don’t respect women at all!"
Some women do not have the power or influence to control their own fertility. Husbands can disregard women’s human rights or abuse young girls with impunity.

This table shows the many reasons given by interviewed women for ending their pregnancy.

Table 6

Reasons given by women why they ended their pregnancy

- Women with induced abortion – 18 women
- Poverty
- Debts or trying to save money
- No work or not enough work
- Unable to work if the pregnancy continues
- Problems with husband, alcoholism, poor quality relationship
- Abuse and violence from husband
- Abandoned by husband or boyfriend
- Widowed
- Modern contraceptive failure
- Using traditional method and failure
- Wrong time to have a child
- Too many children
- Youngest child too young
- Pressured to end the pregnancy by relatives, friends and husbands and boyfriends

Women’s voices

The majority of women interviewed were in paid employment and they had plans for their savings. A newly married woman said …

"I want to keep working for two years and then if I get pregnant I will accept it. Now I don’t want to have a baby."

And a Karen factory worker said,

"I don’t feel sad about losing this baby – it caused me lots of problems. I do want more children in the future but not now. I will take medicine to stop more children."
And a Muslim woman separated from her husband said,

"Every day the debt collectors came and I knew that I would be the one who would have to pay all this money back so that’s why I did it."

Most women were able to tell us their reasons for ending the pregnancy.

A 29 year old married woman with two children in Burma articulated her problems through tears. She has been married for seven years and lived for one year in Thailand and was ten weeks pregnant when she paid 200 Baht for a stick abortion. With eight years of education she was above average.

"The Thai boss is kind and helps us. He found out about the pregnancy and the abortion and he said, ‘Why did you do that? We would look after you and your baby? You can leave it with us if you don’t want it.’ My boss took me to hospital and paid for the medicine. I will pay them back later. The Thai nurse and doctors said ‘Calm down and tell us the truth.’ They cleaned me up and afterwards the pain stopped. They told me that I did a bad thing. They don’t understand why Burmese women do this. They will think that all Burmese women are bad women who kill their babies. When the pains came initially I didn’t know what was happening. People talked about me in the factory and they gossiped and said that because I had so much pain that this was an induced abortion. I got a fever. My husband wants three children. I think we can have another one later in Burma but not now while we are trying to save money."

She is concerned that the Thai hospital staff do not understand her reasons and her husband did not support her decision to end the pregnancy. He had also told her to stop taking modern contraceptives because she experienced side-effects. She is without support and is tearful.

"My husband yelled at me when he found out what I had done. He said ‘You’re the kind of woman that doesn’t like children!’ (She cries and cries at this point in the interview and we stop for a pause).... He is upset with me and he loves children. I did it because I was thinking about my own
children in Burma and I thought it would help him if I wasn’t pregnant. I was thinking of him.”

She is blamed by the Thai medical staff and her own husband all while she feels she is considering the needs of her family. It is a dreadful dilemma and women bear the liability either way.

Other women discussed their situation with their husbands and they made the decision to abort the pregnancy together. A 24 year old husband talked about his wife’s stick abortion at four months.

"I knew she was pregnant. I feel unhappy because I don’t have much money and I feel frustrated. I needed to borrow money to come to the Clinic. We are sad that we are so poor. In the last two months I sent my money to Burma. My wife was sick before the abortion with malaria – it comes and goes. She didn’t take the medicine because she was afraid of it. So she got a high fever and got sicker. She couldn’t work for two months. I need to work to earn money. I think it is not the right time to have a baby. I want to have enough behind me before I have a baby. It is expensive to look after a child. Women can’t work in the factory after they have a baby, the boss doesn’t like it."

In some farm and factory workplaces the choice between pregnancy or the work is another dilemma. A 25 year old Burman woman was intimidated into ending her pregnancy.

"I came to Thailand because the economic situation in Burma is very bad. I work here as a farm hand and we grow beans, fruit and vegetables. I want to go back to Burma in two or three years. At the moment my husband is working with me. He earns 70 to 100 Baht per day. I never had fever before, now I have chills- it is like malaria but it is because I am bleeding. I was pregnant once before with twins. This time when I was pregnant I went to end my pregnancy with the let thay because my female boss didn’t want me to be pregnant. She shouted at me and swore at me. I would lose my job."

Some couples are young and inexperienced. This 19 year old woman from Moulmein married for just six months said,
"I did this because of my economic situation otherwise I wouldn’t have done it. I talked with my husband before making the decision and we decided together. I never understood or heard about family planning (she looks away and is suddenly shy). I’m not sure if he understands about this."

A 22 year old woman with one living child was recently widowed when her husband died in a road accident. She said,

"This pregnancy was four months and I went to do the abortion. I did this because my husband died in an accident. It wasn’t his fault. I didn’t know what to do; no one will look after me. I don’t have any family here."

The idea of raising a child alone and the lack of security motivate her to terminate her pregnancy.

Other women had relationship difficulties or their husband had left them. This Karen woman who had lived in Thailand for only six weeks said,

"If I knew I was five months I would not have tried to end it. I think I am lucky. I am scared and I won’t do it again. I won’t go back to that old woman. I feel so sorry for my baby when I saw it I realised he was older. I did it because I thought I was only two months and my husband had left me. My husband is not good. He went off with another woman."

There are multiple reasons why women end their pregnancies. Later we will discuss issues concerning contraception, as many of these women were attempting to limit their families in ways other than only abortion.
Women and men talking about violence in their relationship

Domestic violence appeared in the research findings in several ways. Six women out of 43 reported living with various forms of domestic violence ranging from emotional abuse to very violent beatings. Three men out of ten disclosed controlling, threatening and beating their wives.

Violence appears to directly cause some abortions and makes other women feel that they do not want to form a family with, and rely on violent men. The women and men were asked about the quality of their relationship and we asked women, ‘Have you ever been in a situation where you felt scared or coerced?’ And we asked men ‘Do you think she [wife] is ever scared or worried by your behaviour or words?’ To our surprise men readily talked about their abusive behaviour and this is a 29 year old Burman man whose wife ended her pregnancy.

“We mainly quarrel at the end of the month before the salary comes. If I want to buy some alcohol she argues with me. Men spend more money. Sometimes I beat my wife but I do feel sad afterwards. My wife isn’t afraid of me though, if she wants to say something she does.”

It is unlikely that this woman is so strong to say whatever she wants, knowing that if her husband disagrees he may beat her.

This Shan man realises his behaviour frightens his wife.

“I can always talk with my wife and we understand each other’s ideas. We never have arguments. I am married for five years already. If she or I did something wrong we can tell each other and accept criticism. The only thing is when I get drunk she doesn’t like it and she doesn’t say anything – I think it scares her.”

And a 25 year old Karen woman,

“I am very scared of my husband. He is three years older than me. He always hits me. I think this is because I was
married before. I have a daughter from this previous marriage. He doesn’t accept that. We argue about this and about money. If we argue about money he hits me. His mother asks for money all the time but we don’t have enough for ourselves. Then when I say this to him he gets angry and hits me and sometimes he gets a knife and tries to cut me. He hasn’t cut me yet but he threatens me. One time he hit me with a plank of wood. There was a nail in the wood and it went into the skin on my back. He kicks me and punches me. I can’t talk with him about my needs. If he doesn’t like what I say he just hits me.”

This Karen woman with a miscarriage talks about her violent husband.

"He doesn’t respect me at all. My husband has had three wives in the past. He flirts around with older women all the time. He smokes, drinks and takes ya ba. When he is drunk he yells and swears at me and I am scared of him. I cannot say anything to him or speak back because I believe he will hit me. He hit me before so I know he will do it. I don’t know how long I can stand this new husband! I am sad most of the time I am with him. He threatens me, ‘I will kill you, I will throw you in the river.’ I am very scared. He doesn’t know about the miscarriage and I worry that if knows he won’t believe me and will take it
This 36 year old Burman man threatens his wife with a knife which must be terrifying for her. His wife had ended her pregnancy.

"We do quarrel sometimes and lately more than normal. About three times per month we have an argument. I think it is because of our economic situation. Sometimes I take a knife and show her but I don’t touch her. I pretend but it is not real."

This Burman woman aborted shortly after being kicked, she has an old scar over her eye.

"I feel very sad to lose this baby because I wanted it. When my husband started to kick me, I was lying in bed. I didn’t feel very well at the time. Then he started to kick me. I don’t think I will get back together with him."

And finally this 38 year old Burman-Muslim woman who induced her own abortion with a bamboo stick.

"My husband always drinks and then he beats me, that’s why I got rid of this baby. I don’t want any more babies. Anytime he gets drunk he screams and shouts at me. I cannot say anything; if I did he would beat me. When he beats me I feel ashamed and cannot talk with people... I give up on husbands and I don’t want any more babies. I want to look after the ones I’ve got already. The babies come too closely together. My husband has sex with me even when I tell him that I am bleeding. He doesn’t listen to me. In Burma we all live in one house and sometimes I am too shy to have sex with my parents and the children around. He doesn’t care. He is violent and loud. I really would like to leave him."

It is common that this woman feels ashamed about being beaten, although it is her husband’s behaviour that is shameful.

The understanding of what constitutes a good relationship between a man and woman is not alien to Burmese culture. Many women articulated their experiences of respect and equality and in
their relationships with men. We include some examples of these to show the difference in the way women talked about their husbands.

"My first husband was bad but I don’t want to talk about that. This husband is not scary. We listen to each other so I do love him and I know he wants another baby.’"

And another woman who has a loud but not violent husband,

"I never feel scared of my husband. He does swear a lot and shouts and complains. When he acts like this I cry. Then he says – ‘This is how I am, my family is always like this and it’s not serious’. But he never hits me."

And again,

"We fight sometimes but I am not scared of him. He listens to me."

And

"He is a husband I can share things with."

The women felt that the sense of fear was a key element. Husbands could storm and shout but they should also listen and share. Most Burmese women felt entitled to speak and have an opinion and not to be threatened by their husband.

While we are aware that women live with domestic violence in every society we were grateful that these women were able to talk about their experience. We were surprised that men were also so frank about their behaviour. Clearly the husbands are aware of the methods they use to threaten, silence and terrify their wives and they understand that it is a way of controlling them. It was not clear from the research whether men understood that some of their behaviour contributed to their wives decision to end the pregnancy.
Conclusions

- Women who complain of ‘weakness’ *ah nee* or who are diagnosed with ‘weakness’ by health workers, should be offered counselling and asked if they wish to delay the next baby.
- Women’s groups or religious or welfare groups should design community support programmes to assist women with ‘weakness’.
- Health workers should be trained to recognise and discuss violence in family relationships with women and men.
- Male community leaders should denounce all violence against women and assist women in their community to live safely.
- Safe houses where women and children can live without fear of male violence should be in all communities.
- Perpetrators of violence should be sanctioned in culturally appropriate ways and when power sharing in Burma occurs, marriage, assault, and rape laws should be reviewed.
- Non government workers supporting migrant workers should develop gender sensitive work practices – supporting claims toward equity of pay and maternity assistance for women in the paid workforce being examples.
- Primary health care clinics for workers should be established in or near large factories and farms that include contraceptive and sexual health advice for men and women.
- Thai public health workers should have access to work places such as factories and farms to offer culturally appropriate health education to Burmese migrant workers.
- Men and women workers should have the option of separate secure accommodation, separate toilets and bathing facilities.
- Non government workers could develop saving funds schemes or micro lending type projects to help families out of debt situations.
Section 5

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Section 5
Planning a family?

For many people the idea of methodically planning children or the idea that fertility can be manipulated is alien. Despite this, in most cultures there exist elaborate and traditional ways to control the fertility of adults, such as restrictions on certain behaviours of young men and women, marriage at specific ages, restricted numbers of sexual partners, separate accommodation or recreation for men and women, long-term breastfeeding, taboo sexual relations between certain relatives or after childbirth, menstrual rules and proscribed sexual activities (McLaren 1990). In disrupted communities such as those affected by conflict, migration or rapid ‘development’, traditions become neglected and fail to fulfil their original purposes. If a healthy and safe environment existed, it would be possible for each woman to give birth to at least eleven children in one lifetime. However in most societies this does not happen due to illnesses and death in women and babies, nutritional scarcity, cultural sanctions that control fertility, consumption of alcohol or tobacco by men and women, or the conscious attempt to decrease natural fertility. People practice many ways to limit their fertility known as traditional methods of birth control such as withdrawal, sexual play without penetration, sex activity at times thought not to be fertile in the woman, herbal medicines, and special charms and magic. Abortion, infanticide and neglectful care of children are also widely practised around the world as ways of either intentionally or unintentionally limiting the number of children (Harris and Ross 1987). In this research we are interested in people’s traditional knowledge and as well as the new ways of limiting fertility.
Traditional family planning

In this study Karen and Burman lay midwives, and informally trained Burmese health workers were asked to list traditional methods of birth control.

Karen farm workers and their babies - 2001

The first group consisted of fifty traditional birth attendant trainers from Karen State (40 females and 10 males) who were asked how women in Karen State, Burma limited their fertility. The second group consisted of forty-four traditional birth attendant trainers, Clinic workers and local Burmese NGO workers who answered a small survey covering some common questions about abortion. The following information was gained through free-listing techniques, open and closed ended questions and informal discussion.
This list is compiled in terms of modern and traditional by their own definition.

**Table 7 How women limit their fertility (50 respondents)**

<table>
<thead>
<tr>
<th>Traditional method of fertility limitation</th>
<th>Modern method of fertility limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root made into a drink</td>
<td>Depo injection</td>
</tr>
<tr>
<td>Eat black sticky rice</td>
<td>Pills</td>
</tr>
<tr>
<td>God decides</td>
<td>Condom</td>
</tr>
<tr>
<td>Pull up, turn or twist the womb or ‘massage' with <em>let thay</em></td>
<td>Tubal ligation T</td>
</tr>
<tr>
<td>Cough out sperms or exercise so they come out</td>
<td>Vasectomy U</td>
</tr>
<tr>
<td>Abortion with <em>let thay</em></td>
<td>Norplant</td>
</tr>
<tr>
<td>Sour stone inside vagina</td>
<td>Kathy Pan</td>
</tr>
<tr>
<td>Tie a thread around woman’s waist</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
</tr>
<tr>
<td>Wash with water after sex</td>
<td></td>
</tr>
<tr>
<td>Wash with a vegetable soap</td>
<td></td>
</tr>
<tr>
<td>Anal sex</td>
<td></td>
</tr>
<tr>
<td>Think about time of month and dates</td>
<td></td>
</tr>
<tr>
<td>Eat a poisonous root or leaf</td>
<td></td>
</tr>
<tr>
<td>Sugar cane and ginger drink</td>
<td></td>
</tr>
<tr>
<td>Eat Chinese papaya</td>
<td></td>
</tr>
</tbody>
</table>

These methods emphasise the multiple traditional ways people living in Karen State may use to attempt to limit their fertility. Interestingly abortion is included in one of the traditional methods and Kathy Pan, a ‘hot’ herbal medicine is perceived as modern.

One senior health worker with experience in working with internally displaced communities generated a list of ways of limiting fertility. She lists 23 methods she is aware people use. She proceeds to group them in different ways such as the method by which they were effective, the strength of side effects on health, how accessible
they were in Burma or how expensive. The following table shows some of her ideas.

**Table 8 Lists of methods of fertility limitation by one senior health worker**

<table>
<thead>
<tr>
<th>Traditional or natural methods with no strong side effects</th>
<th>Most easy to get in Burma</th>
<th>Most expensive to purchase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sugar cane and ginger drink</td>
<td>Certain fruits with <em>let thay</em></td>
<td>Stick abortion</td>
</tr>
<tr>
<td>Certain fruits</td>
<td>Herbal medicine made by <em>let thay</em></td>
<td>Vasectomy <em>U</em></td>
</tr>
<tr>
<td>Kathy Pan</td>
<td>Chinese once a month pill</td>
<td>Tubal ligation <em>T</em></td>
</tr>
<tr>
<td>Herbal medicine made by the <em>let thay</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature method</td>
<td></td>
<td>Massage by the <em>let thay</em></td>
</tr>
<tr>
<td>Withdrawal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucus method</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe days of cycle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drain sperm out of vagina after sex</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Twisting and lifting the womb

Lay midwives who stated they did not practice abortion did offer women traditional family planning by twisting and lifting the womb. This painful procedure is done shortly after childbirth. Both women in the community and lay midwives suggested that it prevented conception, did not ‘dry’ the womb like modern methods and could easily be reversed by another massage-manipulation when the woman desired another baby.

They are probably noticing the period of sub-fertility that naturally occurs during frequent and long term breastfeeding as is commonly practiced by most Burmese women and attributing it to the contraceptive massage.

What is most important is that women from Burma were attempting to delay the next pregnancy to give their body a rest as well as provide adequate nutrition to the growing infant’s development.

A lay midwife adjusting a woman’s womb as she would to delay the next birth
Modern family planning

Offering women (and their partners) a method of contraception after a pregnancy loss is standard post abortion care (World Health Organization and Division of Reproductive Health (Technical Support) 1997) (World Health Organization 2000). Often women have experienced infection and blood loss and need some time to recuperate their strength before trying for another pregnancy even after natural miscarriages. While there is not a direct correlation between the availability of contraception and planned pregnancy – the presence of a service is still important and especially where unsafe abortion is common.

The Mae Tao Clinic staff are aware of the high levels of unplanned pregnancy and unsafe abortions and have offered contraceptive information and supplies to women since 1996. Their own records show an increasing demand and a diversity of contraceptive methods offered to men and women (Sterk 2004). The Mae Tao Clinic records 3,965 patients in the family planning clinic and by 2003 this number had jumped to 6,469, an extraordinary increase (Sterk 2004). The following table shows the quantity of supplies and method mix available to Burmese patients at the Mae Tao Clinic.
## Table 9 Method mix and volume of family planning supplies prescribed in 2001

<table>
<thead>
<tr>
<th></th>
<th>Client</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>717</td>
<td></td>
<td>18%</td>
</tr>
<tr>
<td>&gt;20</td>
<td>3,248</td>
<td></td>
<td>82%</td>
</tr>
<tr>
<td><strong>Number of pregnancies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>248</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>1-4</td>
<td>3,196</td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>&gt;5</td>
<td>521</td>
<td></td>
<td>13%</td>
</tr>
<tr>
<td><strong>Method</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>501</td>
<td></td>
<td>13%</td>
</tr>
<tr>
<td>Old</td>
<td>378</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>Depo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New</td>
<td>462</td>
<td></td>
<td>12%</td>
</tr>
<tr>
<td>Old</td>
<td>562</td>
<td></td>
<td>14%</td>
</tr>
<tr>
<td>Intra Uterine Contraceptive Devise</td>
<td>New</td>
<td>3</td>
<td>0.07%</td>
</tr>
<tr>
<td>Condom</td>
<td>New</td>
<td>550</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Old</td>
<td>232</td>
<td>6%</td>
</tr>
<tr>
<td>Sterilisation</td>
<td>Female</td>
<td>249</td>
<td>6%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>7</td>
<td>0.17%</td>
</tr>
<tr>
<td>Counselling</td>
<td>New</td>
<td>1,021</td>
<td>26%</td>
</tr>
<tr>
<td><strong>Quantity Given</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom</td>
<td>26,022</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pills</td>
<td>2,350</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depo</td>
<td>1,024</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: adapted from Annual Report 2002

During this year 18% of women were under 20 years of age and felt comfortable enough to visit the clinic to talk about contraception and 13% of women had five or more children. Oral contraceptive pills and Depo injections were popular methods and clients returned for more supplies. Condom re-supply fell by half but this may be because men can buy them independently. Intra uterine contraceptive devices are not commonly supplied and long term implants such as Implanon.
Section (5) Planning a family?

are also rare (Sterk 2004). Sterilisation is very much a female method with only seven men accepting a vasectomy in this year. Female sterilisations are not performed at the Mae Tao Clinic, only the counselling and referral to the Mae Sot Hospital. Men do not have to pay for the vasectomy if referred from Mae Tao Clinic. A quarter of patients just needed information and counselling. The burden of fertility limiting falls mainly to women.

The medical records of women who visited the RH OPD during 2001 due to a complicated pregnancy loss show which method of family planning was given to 185 women. Only fifty women or about one quarter of the women were diagnosed with an induced abortion – the others appeared to have miscarriages. This chart shows the type of family planning care given to women after the pregnancy loss.

Figure 6 Post abortion family planning in RH OPD at Mae Tao Clinic 2001 – 185 women
• Mae Tao Clinic offers women a variety of temporary and permanent methods.

• Over half did not receive any modern method of contraception after a pregnancy loss.

• Some women accepted oral contraceptive pills, Depo injection or condoms.

• Two percent of women requested sterilisation after a pregnancy loss.

• Of the fifty women who were identified with an induced abortion, more than half received no method of contraception.

• Out of 15 women who were under 20 years at the time of the abortion only 5 accepted contraception.

• Out of 45 women with multiple pregnancies (5 or more) only 15 accepted contraception.

• Of the 34 women who were referred to the Thai hospital for the treatment of complications arising after abortion, 31 received no modern method of contraception at discharge and three were sterilised.

• There was a positive correlation with the number of times a woman returned to the Mae Tao Clinic and her receiving a modern method of contraception.

While the overall numbers of women accepting a modern method of contraception are increasing at the Mae Tao Clinic, it is concerning to note the low levels accepted by women who are at higher risk, such as young women, women with multiple pregnancies and those identified with an induced abortion. As many of the women have low levels of education or are illiterate, they require more counselling time and creative ways of explaining fertility and contraceptive ideas such as picture books or videos.

If we compare post abortion contraception given to women in the Mae Sot Hospital and Mae Tao Clinic we see a significant difference. While women are inpatients in Mae Sot Hospital they are offered no method except sterilisation which is often not acceptable to young women with incomplete families.
### Table 10 Post abortion contraception in Thai and Burmese inpatient services

<table>
<thead>
<tr>
<th>Method of contraception offered to women on discharge after PAC</th>
<th>Mae Sot Public Hospital (17 women)</th>
<th>Mae Tao Clinic (26 women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Tubal ligation T</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Condom</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Depo injection</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Woman declines</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Not needed</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

- The Thai hospital does not offer women a range of temporary methods while they are in hospital.
- There are language and cultural barriers with the provision of post abortion contraception to Burmese women in the Mae Sot Hospital.
- The Thai hospital asks women to wait six weeks for family planning advice and to return to the hospital or to visit the Mae Tao Clinic.
- Mae Tao Clinic frequently offered temporary and permanent modern methods of contraception while the women were still inpatients.
- Mae Tao Clinic sometimes gives women who are in violent relationships condoms as a method of contraception.

It is very concerning that women are discharged without education, counselling or contraceptive supplies after serious abortion complications at the Mae Sot Hospital. Women who are in violent relationships usually do not have the power to negotiate condom use with their partner. There are several improvements that need to be made in this area for both Thai and Burmese health workers.
Women’s voices

A 31 year old Burman woman from Rangoon who had induced her abortion said,

"I never knew anything about family planning. My friends told me to take the tablets that have the hands pointing and arrows on the packets. I never saw that before. My husband heard about it from his friends and he told me to go and get the injections. I don’t know if it is good or bad. I never used it. I asked one of the nurses if I could get the injections here and she told me that I could. I said to them, well give me that injection!"

The women relied on informal networks, like friend or husbands for information and even when they were in the hospital ward together they taught each other about family planning methods. A 33 year old Muslim woman from Mon State with five pregnancies and three living children told the interviewer.

"All the women on the ward talk about sterilisation because it is easy to do here and very difficult in Burma. Only rich people can afford it in Burma because it costs 120,000 Kyats (12,000 Baht). I come from a small village, nobody there can afford sterilisation so we have too many babies or we do abortions."

Women complained that they were not taught and they needed to know.

"I don’t know about family planning but the other patients talked about the three month pills. The nurses did not talk to me or give me anything to read about family planning. I have no friends to talk with so I don’t find out this information. The Mae Sot Hospital didn’t tell me about family planning or show me anything either."
O Htoo Kler in the IPD was aware that there was a problem with giving women condoms. She said,

"Another difficulty is that we teach the wives and they agree but when they go home the husband gets angry with her for suggesting to use condoms."

A 35 year old Karen woman confirmed the problem,

"I never heard of family planning before as I had no opportunity to hear about it but in the Mae Tao Clinic they taught me about condoms. I have one pack of condoms but I haven’t shown my husband and I don’t think he will use them."

Women were not told when their fertility would return or when they could resume sexual activity with their husbands. This Burman woman had a miscarriage at four months after being chased by the Thai police and was in the Thai hospital when she said,

"I don’t know how many children my husband wants. When this miscarriage happened he was very sad and he cried. My husband does not know anything about family planning. We have never been taught about it. I am not sure when my fertility will return after this miscarriage but I will go back to Mae Tao Clinic but I am not sure when to go."

Men were also not always clear or informed about family planning although more often they could at least read health information.
Desired family size

The medical record review showed that at least half of women had several living children at the time of their abortion/miscarriage and 35 out of 43 women interviewed also had multiple living children. Most women appeared to be delaying the next birth rather than stopping. Of the most seriously ill women admitted into beds, 12 women out of 43 chose sterilisation. Burmese couples generally desire children and usually want three to four and they spoke enthusiastically about their future families. There also appeared to be a generational shift where young couples did not want quite as many children as their parents.

One woman said,

"I don't want to get pregnant so soon. I will use some family planning until my strength comes back."

Men were often keen to have more children than women. This 38 year old Karen woman with a history of two previous abortions and six pregnancies said,

"My husband would like many children but I am ill and old now. I don't want any more babies. Men don't understand this. I asked him if I can have the sterilisation and he said yes so I feel happier now."

The Burmese health workers often felt the same way as their patients. Insien Naw Dah Mala who works in the RH OPD says,

"My ideal family size is four children. This is the best and they should be two years apart. You should not have longer than five years between children. It is not good to have too many children and neither is it good to have too few. The women should take into account what their situation is and how they can support the family."

There is a general cultural difference regarding desired family size between Burmese and Thai people. Thailand has implemented a family planning policy for several decades with almost simultaneous economic and socio-political development (Knodel, Apichat
(5) Planning a family?

Chamratrithirong et al. 1987). Public health standards are good, women and infants rarely die, there are job and education opportunities for men and women and middle class comfort to aspire to if one so wishes.

"Two is enough’ is accepted by most Thai people with the individual and class differences acknowledged. This is not the case in Burma and can lead to misconceptions between Thai health workers and Burmese patients. In particular, all health staff should remember when counselling on permanent methods of contraception that the infant and child mortality is much higher in Burma and ‘two is not necessarily enough”

as babies do not always reach adulthood in Burma [see UNFPA Country Profiles Myanmar for more information on health indicators –http://www.unfpa.org/profile/Myanmar.cfm]

Conclusions

- To try to delay pregnancy is traditional knowledge and many different types of cultural practices are used with varying efficacy.
- All women should receive education and counselling on family planning and especially after any type of abortion.
- Women who have induced an abortion, who are very young, or who have five or more pregnancies should be given longer and more support to understand the benefits of delaying the next pregnancy.
- Women and men should be informed in their own language that fertility will return two weeks after any kind of abortion and given a choice of temporary modern contraceptives at discharge from a health service.
- Thai health workers would be greatly assisted by employing bi-cultural health workers who can teach and explain all aspects of post abortion care, such as nutrition, hygiene and fertility issues in Karen and Burman languages. They could also help doctors collect informed consent for medical and surgical procedures.
Section (5) Planning a family?

• Thai health workers should direct Burmese women to the Mae Tao Clinic reproductive health services if they feel they cannot provide complete health care.

• The links between Mae Sot Hospital and Mae Tao Clinic which already exist should be enhanced to improve referral and information exchanges.

• Women should be screened for domestic violence and not given male controlled methods of contraception if they have little influence in the relationship.

• Sterilisation should be offered to women in their own language but with time to consider the implications of a permanent method of contraception.

• Public health education projects should include men and outline the benefits of family planning to them, for the health of their wives and children.

• Family planning projects should be promoted as improving the health and survival rates of women and children for a strong culture.

• Young couples who need to save money for their future should be helped to delay their family.
Section 6

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Section 6

Health services

The health services for fertility and abortion are varied but not necessarily good quality or accessible. They include the local pharmacy shops, markets, lay midwives, Mae Tao Clinic, Thai Public Health Services and a few public health education materials. In town there are private practitioners and one private hospital but they were not surveyed. In many cases women firstly attempt to use their own local knowledge and by asking friends and family. Very often the kitchen is the first place of call for thway say -‘hot’ medicines and in desperate cases women will insert objects into their sex organs to induce their own abortion and no other person is involved. But having said this, husbands, neighbours, family, employers and the community all exert an influence over fertility and abortion behaviour. There are many points for health intervention and this section is especially relevant for people interested in community health projects.

Markets and friends

Many women said they had discussed their decision to abort with friends or received information where to find medicine or a lay midwife who would perform the abortion from their local neighbourhood. The local pharmacy shops sell traditional and multinational pharmaceuticals. Multinational pharmaceuticals such as vitamins, antibiotics, hormonal to anti-malarial preparations are obtainable without prescription from a health practitioner. We witnessed a teenage girl buying Depo Provera from a Thai pharmacy for intramuscular injection and Syntocinon ampoules for intravenous use for her mother who was a lay midwife.
While it is important that emergency contraception ('morning after pill' commonly called Madonna or Postinor) or condoms are readily available over the counter at a reasonable price, it is alarming that so many medicines are available without any restrictions. This is an area of failing in Thai health policy. Similarly it is possible in Myawaddy to buy bundles of Indian, Chinese, Thai pharmaceuticals with very little guidance of how to take them or the side effects. The local markets in Mae Sot offer medicine like oral contraceptive pills from Bangladesh, Burma and China- some of it out of date, stored in the direct sun and of dubious quality. Market women give incorrect advice about oral contraceptive pills and would benefit from a community education project. *Thway says* such as *Nit kwet say*, *Kathy Pan* and *Que de say* are cheap and widely available and the inserts make no references of what to do if there is infection, excessive bleeding or retained material in the womb. Abortion referrals are also obtainable in the markets.
Let thay – lay midwife

Lay midwives provide maternal and child health care in Burma and also in the Mae Sot area. There are references to their ‘primitive’ practice in the Lancet which shocked colonial medical officers over one hundred years ago (Pedley 1887). A recent article describes how they are included into the Burmese health system and included in post abortion care (Thein Thein Htay, Josephine Sauvarin et al. 2003). They have simultaneously been seen to be the backbone of maternal and child care programmes in developing countries as well as dangerous and deficient (Jeffery and Jeffery 1993; Klein 1995; Miller, Jami-Imam et al. 1995; Xochitl Castaneda Camey, Cecilia Garcia Barrios et al. 1996; Hoff 1997).

As possibly half of women in Burma give birth at home, lay midwives or ‘auxiliary midwife’ with only 6 months of training and who works for free) are a valuable village-level health resource and one still strongly utilised by women from Burma (UNFPA and Department of Health Union of Myanmar 1999; Belak 2002). The ongoing problem in countries like Burma which have an inadequate health service coverage for both trained and informal midwives, is medical backup and referral options for the medical complications that arise in 15% of pregnancies.
Ten to fifteen percent of deliveries need life-saving emergency procedures like transfusions and caesarean sections. Similarly post abortion care also often requires antibiotics, uterine evacuation, blood transfusion and contraception advice in a clinic/hospital setting. The Mae Tao Clinic reproductive health team, who are also informally trained, now provide a high level of post abortion care which includes manual vacuum aspiration (MVA - a safer uterine evacuation procedure than D&C (Todd, Soler et al. 2003)) as well as counselling and education. Not all post abortion care needs to be conducted in the hospital setting by staff who have been to college or university. The question is how can lay midwives reduce their unsafe practices such as stick abortions, feel comfortable referring to medical backup and possibly take on some public health education type activity that would also benefit their own practice?

Lay midwives are a diverse group, especially at the border area where there are access to training points and influences from other cultures. We interviewed and surveyed 70 lay midwives, a minority of whom were men. Older midwives had learnt in an apprenticeship from older relatives, with acknowledgement of the community and usually after childbearing themselves. Some older midwives were also skilled herbalists for women and infants. Younger lay midwives had attended trainings or learnt health skills from other similar roles such as being an assistant worker in a health clinic in Burma. They may not have their own children. Older midwives tended to be cautious about modern contraception or medical interventions in childbirth, while younger midwives were keen to do injections, use IV lines and learn about modern contraception. Most lay midwives knew about abortion but said they did not practice it. Three lay midwives talked about their abortion practice – one did pummelling abortion and two a combination of sticks and pummelling. Two of these lay midwives said they wanted to understand more about modern methods of contraception and health problems associated with abortion.
Mae Tao Clinic

The Mae Tao Clinic offers a comprehensive health service – if people can reach them. The local Mae Sot police do stand outside the clinic and harass and arrest patients but they rarely enter the compound. The Mae Tao Clinic provides culturally appropriate, free health care to the externally and internally displaced Burmese population and is supported by the local Thai Public Health system. The clinic is based four kilometres from the official border crossing and is accessible to local and rural Burmese living in Thailand, as well as Burmese still inside Burma. Overloaded songtows regularly go past the clinic on the highway that leads directly to the bridge to Burma. The Mae Tao Clinic Annual Reports, records contact with over 34,000 patients during 2002, which fluctuates according to season due to the massive morbidity associated with malaria, dengue and respiratory infections in the wet season.

Table 11 Increasing annual caseload at the Mae Tao Clinic

<table>
<thead>
<tr>
<th>Year</th>
<th>Total caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>1,760</td>
</tr>
<tr>
<td>1991</td>
<td>2,339</td>
</tr>
<tr>
<td>1993</td>
<td>6,004</td>
</tr>
<tr>
<td>1995</td>
<td>7,992</td>
</tr>
<tr>
<td>1997</td>
<td>15,272</td>
</tr>
<tr>
<td>1999</td>
<td>26,845</td>
</tr>
<tr>
<td>2001</td>
<td>30,090</td>
</tr>
</tbody>
</table>

Services provided include outpatient care and inpatient care, a tuberculosis program, a child health program, blood donation storage system, laboratory, eye clinic, as well as a trauma and prosthetics clinic. Health workers can attend training and skill upgrade courses in mental health, reproductive health, health rights, information systems, sanitation, landmine awareness and so forth. The clinic also offers referral backup, ongoing training and supplies to lay midwives.
The clinic staff attempt to reach rural and isolated communities in Thailand when the political and security situation allow, as well as visit factories where thousands of migrant workers live and work. They estimate they serve a target population of 150,000. The clinic also coordinates a home for orphans, supports informal schools, boarding houses, women’s organisations and health education in the refugee camps. Each year shows an increase in the numbers of people served. The Back Pack Health Worker Team coordinates closely with the clinic and provides primary health care inside Burma to an estimated target population of 130,000 displaced people with teams of community health workers and midwives. This is a highly dangerous project for the workers as they are perceived as insurgents by the SPDC. The whole operation to provide primary health care services to a marginalised, displaced and ‘illegal’ population is conducted by hundreds of local staff, many volunteers who are often foreigners and is supported by multiple international donors and charities. Some Thai officials also recognise the benefit of having a health service dedicated for Burmese people funded largely outside of Thai health funds (Sanitsuda Ekachai 2003). One of the many unique aspects of the Mae Tao Clinic is that people of all nationalities and ethnicities, Buddhists and Christians, work and live together despite difficulties and uncertainty.
Women and children’s wellbeing

The lack of birth registration and citizenship for Burmese infants born in Thailand either in or outside the refugee camps, family separation and community disintegration, lack of access to health services and organised crime are health and security issues for the forcibly displaced. Children without identity papers are easily recruited to be child soldiers and the community fears when people are allowed to repatriate, their citizenship in Burma may be denied. There are an estimated 40,000 children in Thailand born to Burmese parents who are effectively stateless, neither Thai nor Burmese, who cannot enter Thai schools and who have limited employment opportunities in the future (Nyo Nyo 2001). Parents do consider their children’s future and how much this is a part of the unwanted pregnancy experience for Burmese families is unclear. Each year babies are left at the clinic when new parents find they cannot care for another child.

Post abortion care and other reproductive health services

In 1990 the staff began a delivery and referral service that expanded in 1991 to the mobile teams for the internally displaced. In 1992 a three month maternal and child health training course for health workers was implemented. During the 1990s several small outlying clinics which provided maternal and child health care in Karen State were burned down by the SPDC. In 1997 a blood transfusion and storage system, (vital for emergency obstetrics) was established and better coordination with the Thai Public Health system began. By 1998 the Backpack Health Workers were accessing people in Karen, Mon and Karenni areas and a small grant came through for maternity care from the Women’s Commission for Refugee Women and Children. The health workers report the numbers of post abortion care patients is a stable trend. It is very difficult to draw conclusive results from the numbers of women attending the Mae Tao Clinic for several reasons. The number of births does not reflect the incidence in the community as many are conducted with lay midwives at home. The numbers of beds available dictate the cases seen and not incidence in the community, and in the
case of post abortion care this only began to be recorded in 1998. It is not possible to draw a delivery abortion ratio from this type of data but the abortion figure appears to be static.

**Figure 7 Numbers of births and post abortion care over the years at Mae Tao Clinic**

Source: Annual Reports nb. PAC was not recorded before 1998

The funding for women’s health was only US $20,000 in 1999 and had grown to US $210,000 by 2002. During 1999 the training of traditional birth attendants in migrant worker and IDP areas began and a reproductive health workshop was organised regularly to review cases and refresh knowledge. A separate emergency obstetric referral system was developed in 2000 and the training of lay midwives continued. By 2001, 300 lay midwives had some form of training in bio-medical obstetrics covering topics such as hygiene, nutrition, abnormal birth presentations, referral, family planning and aspects of infant health. In 2001, adolescent health issues were also beginning to be addressed by a needs survey and the Monitoring and Evaluation Quality Improvement Project funded by the Women’s Commission was
underway. During 2002 the Averting Maternal Death and Disability Project began and all emergency obstetric referrals were reviewed and the problem of unwanted pregnancies and unsafe abortions was analysed. More recent data shows improvements in treating patients after any type of abortion and less referrals.

Thai Public Health

The Thai public health system is well developed and there is a network of public health centres at the village level, district hospitals, regional hospitals and major teaching hospitals that are relatively easily accessed by Thai citizens for minimal costs. The introduction of the 30 Baht health insurance scheme has also improved accessibility. In the Western part of Tak province which includes five district areas, in 1999 there were 26 village level health centres (anamai), one public general hospital (310 beds) and one private hospital (120 beds); there were also three designated malaria clinics.

The Mae Sot Hospital had been extended and the new obstetric/gynaecology and administrative buildings are very modern. The hospital has outpatient, inpatient facilities with adult and neonate intensive care units, operating theatres, radiology services, physiotherapy, pharmacy, department of nutrition, department of community and social medicine, a medical library and department of education and public relations – a sophisticated hospital by anyone’s standards. Over 700 staff work there in preventative, curative and rehabilitative medicine.

In 1999, the outpatient department saw 167,292 patients or an average of 585 each day and 10% of them were Burmese. In the same year 17,504 patients were admitted into beds and one quarter of those were Burmese. The leading causes for admission to the hospital are the complications of pregnancy and normal deliveries, malaria, intestinal and respiratory infections. The leading causes of death at this time were malaria, AIDS, infectious diseases and pneumonia.
Reproductive health services at the Mae Sot Public Hospital

The percentage of women who give birth in a hospital in the whole Kingdom is 77% while for Tak it is only 34.6%. Many Burmese women deliver at home so the numbers recorded by the hospital do not reflect the actual number of births in the area – this means that much of the official data is not representative and can only be used as a guide. The following table shows the figures of births, stillbirths, abortions and maternal mortality recorded by the local Thai hospital. The increasing trend of women attending the hospital for reasons relating to abortion while the number of births has remained static is interesting and opposite to the findings at Mae Tao Clinic.

Table 12 Births, stillbirths, abortion and maternal deaths at the Mae Sot Public Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Births</th>
<th>Stillbirths</th>
<th>Abortions</th>
<th>Maternal Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>2,242</td>
<td>33</td>
<td>265</td>
<td>5</td>
</tr>
<tr>
<td>1998</td>
<td>2,170</td>
<td>30</td>
<td>403</td>
<td>2</td>
</tr>
<tr>
<td>1999</td>
<td>2,191</td>
<td>39</td>
<td>277</td>
<td>1</td>
</tr>
<tr>
<td>2001</td>
<td>2,216</td>
<td>37</td>
<td>360</td>
<td>10</td>
</tr>
<tr>
<td>2002</td>
<td>2,322</td>
<td>42</td>
<td>442</td>
<td>4</td>
</tr>
</tbody>
</table>

One of the major causes of hospitalisation and death for women during pregnancy is malaria and it is also the reason for many stillbirths. All women are vulnerable but especially Burmese women due to their living conditions, poorer state of health than Thai women and the barriers to receiving health care. A large number of women come to the hospital to deliver with no record of any antenatal care and others come late in their illness. The cost of an uncomplicated delivery is between 1,500 to 1,800 Baht. The Public Health Statistics 1998 (Ministry of Public Health 2000) collected data from 1995 to 1996, and recorded infant death at 4.7/ 1,000 live births and maternal death ratio at 7.6/ 100,000 live births in Tak province.
Public Health Education

There are written pamphlets available on modern methods of contraception in Karen and Burman languages produced by various NGOs and Thai Public Health and these are very useful. There is one rather curious poster by an international NGO on the topic of family planning which shows a poverty stricken family in traditional clothes with eight children. The couple look worried, thin and old, and the children are malnourished. In the next panel the same (or similar couple) now only have two fat children, a boy and girl. They sit comfortably on a bench, smiling youthfully and the man appears to have transformed from an iterant farm worker to a middle class gem dealer with a clean shirt with collar and longyi. In short it is a cliché and a sad one. While having less children may make it easier to make sparse resources like food go further it will not miraculously end poverty or supply universal education to marginalised people. This is the role of good governance and inclusive citizenship which are political issues. Family planning promoters need to think carefully about their health propaganda. Similarly there exists a one page black and white illustrated health warning on the dangers of induced abortion. Rather predictably the woman ends up dead – this too is trite – few women die from abortion and most women already know that this is one of the risks. Women (and men) deserve a higher quality of public health education materials that give real information, suggest alternatives or offer referral information and stay away from the fear provoking elements of health. One NGO broadcasts radio information in Karen language and they have produced some high quality work. Most women can read at a simple level and culturally appropriate pictures are always a useful way of imparting information. Many of the women interviewed were very curious to learn more information and accepted health education in verbal or written form. There was some public health education activities occurring in brothels and factories but were limited and conditional on the owner allowing entry. Many public health education opportunities are missed.
Conclusions

• Providing educational opportunities for children is important as it gives a sense of hope for the future.

• Children should be offered some identity papers so they may go to school and eventually back to Burma with their parents.

• Organisations which support temporary nurturing and long term adoption of Burmese children should be promoted.

• The Mae Tao family planning clinic as an out patient and also out reach service should be expanded.

• Mae Sot Hospital family planning clinic should have bi-cultural workers who can communicate effectively with Burmese patients.

• Men should be offered family planning information in culturally appropriate ways by male health workers.

• Lay midwives should continue to be trained but an advanced module on abortion and family planning should be developed for them.

• Liaison workers who re-supply lay midwives birth kits and assist with referral should be promoted.

• General health data should be sent to the Myawaddy Township hospital to notify the health director of how many of his patients were treated in Thailand.

• The production of factual, calm and informative health information on abortion and contraception should be produced for the diverse Burmese community.

• Songs, plays, picture books, posters, radio programmes, videos which are interesting, as well as educational should be produced in multiple local languages.

• Outreach projects on sexual health issues in the markets, factories, construction sites and farms would reach the intended audience in Thailand.

• Short courses for pharmacy assistants on how to prescribe emergency contraception and other contraceptives correctly as most women buy over the counter and do not seek a health professional’s advice.

• Health information products should also be sent into Burma.

• Thai Government should restrict the access of the general public to some medications particularly hormone injections, oxytocics, high dose oral contraceptive pills (> 0.30 mcg Oestrogen) and hormonal preparations used during menopause.
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Concluding Remarks

Abortion is a common and serious problem for women from Burma. Many pregnancies are unplanned, and without access to legal, safe abortion women use their own local knowledge to end their pregnancies. In this area most women who experience an early pregnancy loss are in married relationships and already have children. Most women are in paid employment and contribute to at least half of the family income.

Pregnancy interrupts family plans to save money, pay off debts or feed the extended family back in Burma.

Women also spoke of wanting to space their children for health reasons associated with ‘weakness’. Most Burmese men and women expressed a desire for several children in their family, once the social and political conditions improved.

Domestic violence was a significant feature of some women’s decision to end the pregnancy. Some women secretly ended the pregnancy without their husband’s knowledge but in most cases the husband knew and helped the woman reach the let thay and paid for the abortion.

Knowledge of modern methods of contraception was low and older let thay were often suspicious of the side-effects but younger let thay were interested to learn more. The husbands in this study were more literate and educated and were able to read health education messages but they often left the responsibility of trying to limit the number of children to their wife. Burmese men need to be taught to understand how to protect their wives’ and children’s health by supporting family planning.

Health workers underestimate the numbers of induced abortion in their case note recording, and if there are language barriers this adds to the confusion. Most of the health workers interviewed understood the phenomenon of induced abortion well, and could state the how and why the women would attempt to abort. But they often
missed cases of domestic violence. Thai nurses are unable to explain basic health education to patients in their care due to language and cultural differences.

The most serious problem being that women are expected to return to the hospital for family planning supplies at six weeks after their abortion. Firstly, women can conceive at two weeks after abortion and secondly it is not possible to travel freely in this area. This policy needs to change and Burmese women need to be given education and supplies while they are still in-patients. The Mae Sot hospital did provide skilled post abortion care in other respects. Health workers need to be able to offer women hope and options when counselling them about unplanned pregnancy. Social support and welfare projects for families experiencing difficulties in raising children need to be expanded.

While the numbers of patients attending family planning clinics at Mae Tao Clinic is increasing tremendously each year, the women who are most at risk of unplanned pregnancy do not always receive a modern method of contraception. If it were possible to spend more time with women who were suspected of inducing abortion, young women, women with multiple pregnancies, women who need to earn an income and those complaining of ‘weakness’ as they enter the OPD, perhaps better quality counselling and education could be given. The introduction of manual vacuum aspiration (MVA) has improved the provision of post abortion care and lessened referrals to Mae Sot hospital. An area of future research would be to examine patients’ satisfaction with their care and the management of pain and suffering.

*Let thay* need to be taught about the hazards of induced abortion for women and how to refer women who have signs of infection, excessive bleeding or extreme pain after traditional abortion or spontaneous abortion. Not all induced abortions result in pelvic infection or death but a significant number of women become very ill due to the traditional methods of pummelling and stick abortions. *Let hay* who perform abortions should not be persecuted as they are responding to a community need to delay pregnancy but provided with education and referral processes. *Let thay* would benefit from family planning education and could be included in social marketing type projects. Moreover market women would also be a receptive group for family planning education and social marketing. The Burmese men and women who live along the border of Thailand would benefit from creative, low
literacy, culturally appropriate health education programmes delivered into work and recreation areas.

Unplanned pregnancy and induced abortion related illness and death are avoidable tragedies.

As both Thailand and Burma are signatories to the Convention on the Elimination of All Forms of Discrimination Against Women (1981), women’s human right to health needs to be taken seriously. Women have the right to work and have the number of children they wish. They have the right to understand about their bodies and have access to modern methods of contraception. They have the right to high quality reproductive health services.

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Concluding remarks


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Appendices

Ideas about fertility

There are generally three ways people talk about fertility. We will explain them so that you can understand the issues behind each idea.

Population control

This is the idea that the numbers of births can be increased or decreased by government policy and programmes. Negative population control is the idea that the world is a limited place, that there are too many people and not enough resources for everybody. Very often people give the example of the destruction of natural resources, global warming and pollution problems or they will say that poverty is caused by too many people. Furthermore, too many babies are seen to be a threat to development and modernisation aspirations. Women’s bodies are often the target of government policies which attempt to restrict the number of pregnancies occurring. Often permanent or long term methods of contraception are offered cheaply or at no cost to women, and sometimes even men are asked to have vasectomies and are given presents if they accept. Abortion is legal and available. Countries like China, India and Bangladesh have government policy driven by this type of idea.

Population control can also be used to increase the population. In this case certain people are encouraged to have many children. They are seen to be endangered or the number of a particular group of people is thought not to be big enough. Women and men are encouraged to have many children; sometimes they are offered money, free children’s education or free hospital care if they have babies. Women are expected to stay at home and care for the children and not do paid work. Contraception is not encouraged and abortion is
Countries that experience political conflict and war often try to increase their population numbers. This is common in countries where there is no quick political solution and so each group of people try to outbreed the other and ‘win’ by numbers alone. Very often only certain groups of people are encouraged to have many children and this is often phrased in nationalistic, patriotic and survival type language. Sometimes rape and enforced pregnancy is used to destroy the ethnic identity of the enemy. Countries like former Yugoslavia and Burma are examples.

**Argument against**

In the world today a tiny rich minority of people use most of the land and hold most of the wealth. Large international companies trade weapons, money and consumer goods and destroy much of the world’s environment. Poor people would probably have enough if rich people would share the wealth and the land. Poor people have children because of the pleasure of being a parent and also because they provide help for the family to survive together. In situations of instability, people feel secure surrounded by their family. Usually in population control type policy strong coercive methods are used to control people which many would argue are wrong.

**Maternal and child health**

Basic delivery and baby health care are offered but rarely services for other types of reproductive health needs such as family planning, sexually transmitted infections, sexual relationship problems, rape or abortion. Women’s needs are not seen as different to children’s needs. Ideas of maternal and child health care often see women as pregnant mothers only and does not offer health services to men who are seen as not having these types of problems or interests. Unless people are married and already in sexual relationships they are not
considered recipients of health care. The focus is strictly on health issues, risk assessment, provision of care and collection of data. Often social or cultural elements of health are ignored and political concerns are not included. This is the type of restricted health care is often found in refugee camps which have limited funding or trained staff or in countries who have to accept international funding to maintain basic health services. In developing countries two systems of maternal care often operate simultaneously – the traditional system and the newer health programme, they are usually not integrated, and they do not trust or understand each other.

**Argument against**

Most communities take care of pregnant women in some form – the argument usually is over who should care, how it should be given and if it costs who should pay? In this context safe abortion is often not seen as maternal health care but something entirely different, so counselling, education, abortion, or post abortion care are not provided. Additionally women are often blamed for not wanting to be mothers of many children. People who have not yet begun sexual relationships, or who are in different types of sexual relationships like young people, sex-workers, gay people also need sexual health information.

**Reproductive Health Rights**

Reproductive health rights stems from the Universal Declaration of Human Rights and the history behind the idea that all people are equal and entitled to be treated with dignity. All of the human rights are important and can not be separated or treated more importantly than any other. When this is related to reproductive health it means that all people have a right to understand and control their own reproduction, apart from what a government may want for its population. Men and women are entitled to enjoy their sexual lives, choose who they marry, when they want to marry and how many children they want. The conventions and treaties that give form to human rights continually evolve and have in recent decades begun to consider reproductive health rights. The following International Conventions and
consensus documents are of interest regarding this report (Cook and Fathalla 1996; de Bruyn 2002):

- Universal Declaration of Human Rights (1948)
- Convention relating to the Status of Refugees (1951)
- Covenant on Civil and Political Rights (1976)
- Covenant on Economic, Social and Cultural Rights (1976)
- Declaration and Platform for Action of the Fourth World Conference on Women (1996)
- Convention of the Protection of the Rights of all Migrant Workers and Members of their Families (2003)*

Each of these international documents articulates a growing belief system of the inalienable, indivisible rights of human beings in all spheres of human activity which includes women and specifically refers to their reproductive and productive capacities. They include in general overview the right to life and survival (of children and adults), the right to liberty and security, the right to the highest standard of health, benefits of scientific progress, to receive and impart information, the right to education. Regarding other social rights, the right to marry and found a family, the right to decide the number and spacing of children, the right to a family life, non-discrimination on the grounds of sex, age and to be free from inhuman and degrading treatment. Once a state has ratified a convention it is then legally obliged to respect the rights mentioned in the convention, protect those rights by taking some action and fulfil the obligations in a real way by providing resources. The policies that stem from this type of thinking involve health education programmes for young people and adults, access to affordable health services, privacy, and the choice of when and how many children a couple wish to have. Women are perceived as equal human beings entitled to quality health care.

* Even the Guiding Principles on Internal Displacement, United Nations and OCHA (no date). Guiding Principles on Internal Displacement, endorsed by the late Sergio Vieira de Mello, call for special attention to the needs of internally displaced women and their reproductive health care – Principle 19, Subsection 2.
Burma and Thailand are signatories to very few international humanitarian treaties. Neither are signatories to the Refugee Convention (1951) or the Convention of the Protection of the Rights of all Migrant Workers and Members of the Families (2003). Both signed the Geneva Convention, Thailand in 1954 and the Union of Myanmar in 1992 and both countries have signed and ratified the Convention on the Elimination of All Forms of Discrimination Against Women (1979) – hereafter called CEDAW. Thailand signed in 1985 and Burma later in 1997. The Union of Myanmar offered its first CEDAW report to the committee in the United Nations in 1999 which strenuously declared that men and women had pure equality and freedoms in education, employment, law and politics despite ethnicity and location. This was challenged by the CEDAW related document *Gathering Strength Women from Burma on their Rights* (Belak 2002) which argues that the Union of Myanmar is not upholding its obligations to CEDAW. In any power sharing situation in Burma that may eventuate, all community leaders will need to understand and work towards the international CEDAW standards.

**Argument against**

This leaves people too much freedom to decide by themselves, people are irresponsible and ignorant and only leaders can make the correct decision for people. Human rights are an idea introduced by foreigners and do not apply to Burmese people who are different. Women especially should follow traditional behaviour and not be knowledgeable about sex and should accept nature or God’s gifts. None of these rights can be enforced anyway so they are not important to think about. Only human rights for democracy or political activities are important. It is interesting to watch for people who often will accept other human rights statements but not those concerning reproductive health rights as this is illogical thinking or ‘double standard’ rights.

**Research Methods**

A small research team worked during 2002 to collect information from Mae Tao Clinic, the local Thai hospital and Burmese and Thai health workers. Information was collected in the town and in the rural
areas about 30 to 40 km outside of town. Young and older lay midwives also gave information and some of them admitted to performing abortions for Burmese women. Burmese women who were admitted as patients in the Thai hospital or the Mae Tao Clinic were asked to give a confidential interview and give permission to speak with their husband.

As we were interested in abortion and particularly induced abortion, the research methods used for this study were a combination of quantitative and qualitative. This means both numbers, people’s statements, and meanings were thought to be important. It seemed essential to try to count some elements but also to listen to what people were saying and observe what they were doing. From reading the literature we decided that a KAP (Knowledge, Attitude, Practice) survey would probably not elicit the subtle and secret information we needed in order to understand the full situation.

Private and secret

Abortion, pregnancy loss and fertility are very private matters that most people will not openly talk about and so it is remarkable that in this study we have 43 women talking for at least an hour each about their experiences. The names of women were never recorded and we talked with them in a private room. Despite this seven women said they would not talk with us when we approached them for interviews. Furthermore we thought it was important to be gender and culture sensitive and only have the same sex interviewed the same sex. The research team spoke Burmese, Sgaw Karen, Thai and English.

Samples and recruiting

All of the medical records from one year (2001) that dealt with any type of pregnancy loss in the Mae Tao Clinic Reproductive Outpatient department were reviewed for bio-medical and social information as well as those Burmese women referred to the Mae Sot Hospital for more intensive medical treatment. Several hundred medical records were checked for information such as age, pregnancy outcomes, treatments, laboratory results and family planning information. It is
unique in that both Thai and Burmese health facilities, as well as trained and lay health workers cooperated in good faith to share information for the purpose of this study.

Information was collected by retrospective and current medical record review, semi-structured interviews, group discussions, community meetings, visits to informed people such as monks, politicians, administrators and non-government organisations. Additionally, the researchers lived in the community for ten months and visited places such as the local market where much health information is dispensed and collected local medicines and referrals.

Problems and limitations

This study is not random. We did not just ask anybody and everybody but sought out the women who were coming to health services because they had a problem. This means that this study is biased toward those women who experienced a health difficulty associated with abortion. There probably are many women who have a miscarriage or induce their own abortion and stay at home and cope by themselves, just as most Burmese women in Thailand birth with the lay midwife. This also probably means that we spoke with those women with the worst outcomes from unsafe abortion practices. This is always a problem with any hospital based research. To counteract this we interviewed people in the community as well as reading other types of research. Very few foreigners were interviewed; the majority of people who gave information were from Burma therefore it predominantly reflects the attitudes and beliefs of this diverse group of people. It is also limited by the small samples and in particular the responses of men as partners (10), women who lived with domestic violence (6) and the abortionists (3). Despite these shortcomings we believe that this report will provide a clear statement of the problem, an analysis and some suggested solutions.
If you have access to the world-wide-web from a computer there are many resources and reference material that can help you understand issues on fertility, contraception, abortion and reproductive health rights. It is possible to develop a good reference library by printing from the computer and also to ask for free copies to be sent to you through the post. Here is a list of the most helpful sites. Remember it is most important to type exactly!

- Safe Motherhood and Abortion
  - http://www.path.org/programs/womenshealth.htm
- Family Planning, Sterilisation and consent form
  - http://www.who.int/reproductive-health/publications/
- Emergency contraception
  - http://www.cecinfor.org
  - http://www.plannedparenthood.org/ec/
- Refugee Health
  - http://www.rhrc.org/
- General Reproductive Health
  - http://www.rho.org/
  - http://www.reproline.jhu.edu/
  - http://www.asia-initiative.org/
  - http://www.agi-usa.org/
- Reproductive Health Rights and Violence Against Women
  - www.crlp.org
  - http://www.ipas.org/
- Reproductive Health Matters – a journal in English language about reproductive health around the world
  
Centre for Mexican American Studies, University of Texas.