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Citation for author's submitted version

Citation for publisher's version

Notice: The publisher's version of this work can be found at:
http://dx.doi.org/10.1080/07399330601180081
Borders of Fertility: Unplanned Pregnancy and Unsafe Abortion in Burmese Women Migrating to Thailand

Burmese women are forced to migrate to find work and security in Thailand due to the social, political and economic disarray present in Burma. Unplanned pregnancies are common in this area and one third of pregnancy loss is self-induced. Poverty, lack of employment rights and domestic violence are important factors in deciding to terminate the pregnancy. Women face multiple barriers in managing their fertility and use traditional techniques often with the help of lay midwives. The research methods include a retrospective review of medical records held in Thai and Burmese-led health facilities, as well as semi-structured interviews and group discussions with Burmese women experiencing a pregnancy loss, Burmese traditional and modern health workers, and their husbands and community members.

Key words: Family planning/ abortion/ Thailand/ Burma/ migration/ refugee
During 2001 to 2002, I studied reproductive health issues in relation to abortion and family planning among migrant-refugee Burmese women in the Thai province of Tak. Burmese women face difficulties concerning their reproductive health and specifically gaining access to appropriate health services for fertility issues and safe abortion, both inside Burma, and while they live in Thailand. Despite this, they have a variety of ways of controlling their fertility, which vary in efficacy and safety. The community of Burmans and ethnic minority people that I work with refer to their country as Burma (therefore so do I), while the current military regime, the State Peace and Development Council names the country the Union of Myanmar. This study focused on women living in Thailand outside of the United Nations High Commission for Refugee system of camps. The population of interest to me were those Burmese who had crossed the Myanmar national border and had entered Thailand but who had not entered a refugee camp. In Tak province there are 60,520 registered, and an estimated 150,000 unregistered, migrant workers from Burma (personal communication World Health Organization, Bangkok 2003). Many migrant workers in Thailand flee the social and political problems that presently engulf Burma (Asian Migrant Centre & Migrant Forum in Asia, 2003). These Burmese migrant workers in Tak work in farming, factory garment making as well as domestic service and sex work (Images Asia 1997; Pim Koetsawang 2001; Awataya Panam, Khaing Mar Kyaw Zaw, Caouette, & Sureeporn Punpuing, 2004). Despite Thailand’s developed public health system and infrastructure they find access to health care difficult. Burmese women face language and cultural barriers, and marginal legal status as refugees in Thailand, as well as a lack of access to culturally appropriate and qualified reproductive health information and services causing serious reproductive health problems (Belton, 2005).
BACKGROUND AND PURPOSE OF THE STUDY

Unwanted pregnancies and the lack of access to contraception are major public health issues in Burma (UNFPA, Department of Health 1999). The Myanmar Department of Health ranks abortion in their top ten health problems for the country and the third main cause of illness. Thein Thein Htay, Savaurin and Kahn (2003) estimate maternal mortality in the region of 255/100,000 and Ba Thike (1997) some years earlier suggested that at least half of the deaths of women due to pregnancy related reasons were related to abortion. In addition, Ba Thike recorded the complications from abortion as comprising 20% of all hospital admissions. For displaced Burmese women or those who live in remote areas of Burma, the estimated maternal mortality increases to 580/100,000 (Lanjouw 2001), which reflects in part their lack of access to health services and their marginality in relation to the Myanmar state. In contrast, the Thai Public Health Statistics 1998 (Ministry of Public Health, 2000) collected data from 1995 to 1996, and recorded maternal mortality ratio at 7.6/100,000 live births in Tak province.

At the time of this study it was only possible to obtain a legal abortion in Burma if the woman’s life was in danger, while slightly less restrictively in Thailand, induced abortion was sanctioned if it was likely to save the woman’s life, or in cases of proven rape or incest. Modern methods of contraception are not widely used in Burma. The United Nations FPA (2003) estimate that 28% of fertile-age women in Burma use a modern method of contraception, in contrast to Thailand, where 72% of adult Thai women use modern contraception (UNFPA Country Profiles [July 2003]). These findings indicate an unmet need for fertility control, which Burmese women
meet by using their own local knowledge. This study aimed to document the problem of unsafe abortion for Burmese women living in a border province in Thailand.

Although few studies have examined abortion issues for migrant workers in Thailand, the Ministry of Health (2001) recorded a rate of abortion 2.4 times higher than that of the local Thai population. Caouette et al (2000) found that untrained people perform most induced abortions and traditional (lay) midwives conducted abortions in 44% of cases. Women used a variety of ways to induce an abortion such as home remedies, herbals, Western medicines and insertion of objects into the sexual organs (Belak, 2002; Shakti, Supang Chantavanich, & Naing, 1997; UNFPA & Ministry of Immigration and Population Union of Myanmar, 1999). There is an increasing body of literature that calls for women in situations of forced migration (and those who are recognised refugees) to have access to reproductive health information and services (Lehmann, 2002; Schreck, 2000).

International perspectives

There are an increasing number of countries which have liberalised access to safe elective termination of pregnancy (Rahman, Katzive, & Henshaw, 1998). Over 90% of the member states to the United Nations are party to the international Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) which states that women have the right to freely decide the number and spacing of their children and to have access to family planning (United Nations, 1979). There are several useful tools readily available for professionals and policy makers who wish to implement safer reproductive health services which can prevent large numbers of women presenting to overwhelmed acute health care centres. The World Health Organization’s Safe Abortion: Technical and Policy Guidance for
Health Systems is a resource for managers and is produced in multiple languages (WHO 2003). For those professionals working with internally or externally displaced women the Department of Reproductive Health and Research has produced A guide for programme managers focusing on reproductive health during conflict and displacement (World Health Organization & Department of Reproductive Health and Research, 2000). If doctors, nurses and midwives want to refresh their skills in supplying contraception to women after any kind of abortion experience, Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use is available (World Health Organization, 2000). Many of these resources are free to poorer countries and can be downloaded from the internet.

Setting
In Tak province there are limited health services for migrant workers and many utilise the Burmese led primary health service called the Mae Tao Clinic which is just 4 km inside the Thai border. I conducted the research in collaboration with Dr Cynthia Maung, a Karen (Burmese) medical doctor, and director of the Mae Tao Clinic. A Thai obstetrician, the head of the gynaecology and obstetric department in the Mae Sot General Hospital, also guided the study. Shortly after the 1988 democracy movement a group of exiled Burmese university students established the Mae Tao Clinic. The Clinic is unique in that while it is largely financially supported by the international community, it is directed and run by refugees from Burma and is tolerated by Thai authorities. In the past some of the Burmese health workers had work permits issued by the Thai Government. The Mae Tao Clinic is the most culturally appropriate health service for Burmese people seeking health care, as many of the health workers not only speak a variety of Burmese languages, but also have similar life histories to their patients. Burmese migrant workers also visit the local
Mae Sot General public hospital, private clinics and pharmacies. Alongside these institutional health services women in the food and flower market are also sources of health information and service. They sell patented herbals, cosmopolitan pharmaceuticals and give referrals of where to find abortionists. The medicine and advice available in the local market is often out of date and of dubious quality.

The quality and accessibility of these services to women varies. In 2002, the Thai Thaksin government introduced a popular universal health insurance scheme that aimed to reduce health inequalities. If a Burmese migrant carries a work permit, they may travel and use the 30 Baht universal health insurance scheme in Thai public health facilities, but the climate of fear and uncertainty can stop people travelling. Passengers on public transport must pass through many roadblocks and checks, and if they are discovered not to have the correct papers, they are ‘fined’ or deported. Even when Burmese migrants hold papers they are often harassed by Thai authority figures such as the local police and soldiers. While the hospital, private and public health clinics usually offer good quality services, the cost, language and cultural barriers pose problems for Burmese.

Theoretical stance

Critical anthropology takes account of power and the political economy and how this is mediated through the body and expressed as distress, disease or illness (Farmer, 2003; Kleinman, 1995; Scheper-Hughes & Lock, 1987). Feminist approaches which value women’s perspectives meanings and experiences also informed my research (Clare & Hamilton, 2003; Maynard & Purvis, 1994). Furthermore, notions of citizenship and human rights are important to any analysis
that intends to be applied, critical and women-centred (Gruskin, 2000; Petchesky, 2003). I have intentionally privileged women’s voices.

**METHOD**

I used quantitative and qualitative methods to generate the data. Free lists, semi-structured interviews, patient medical records as well as hospital recording systems informed the study. Only Burmese men and women, and Thai and Burmese health workers were recruited. I lived onsite for ten months, observed, and participated in the general activities of the Burmese refugee-migrant community.

**Data collection and sample**

One hundred and eighty medical casenotes of women who attended the outpatient Department of the Mae Tao Clinic with any type of abortion (natural or induced) during 2001 were studied retrospectively. Additionally the records of 31 Burmese women who were referred to the local Thai public hospital for emergency post-abortion care were viewed. And the hospital casenotes of 14 women who died while pregnant or shortly after birth during 2001-2002 were also recalled. Any Burmese woman with early pregnancy loss or pelvic injury indicative of unsafe abortion who was admitted to either the Mae Tao Clinic or the Mae Sot General Hospital during six months in 2002 was invited to give an interview. Forty-three women consented and were taken to a private room and interviewed in Burman or Karen language by a female research assistant. Very few women declined to be interviewed. Ten men who accompanied their wives to hospital agreed to be interviewed after their wives had given permission for them to speak with the researchers. The men were interviewed by a male research assistant. Women, men and health workers were also asked to generate a list of answers to the open ended question, ‘How can a woman control her fertility?’ In addition, 20 urban and rural
based lay midwives were interviewed in their homes. Community leaders, political activists, worker’s rights activists and other health workers also offered insights and assistance with the research.

Abortion and sexual health issues are particularly difficult to research due to the associated stigma and criminal status (Whittaker, 2002). This is especially the case when some of the traditional community midwives are not only ‘illegal’ residents in Thailand but some of their practices are also legally proscribed. Access to informants was restricted because of the security situation and stability of the Burmese population in Thailand due to the political climate within and between Thailand and Burma. Moreover, cross-cultural work is always challenging when dealing with diverse ethnic groups with vested interests and divergent political positions.

Data analysis
I recorded field-notes on a daily basis. Medical casenotes were scanned for demographic, bio-medical and social information. Interviews were recorded by hand, translated and entered into Atlas ti software (ATLAS.ti Scientific Software Development GmbH, 2002). Field notes and interviews were managed as hermeneutic units, bundled according to informant; woman, man, traditional health worker, bio-medically trained health worker or sex-worker. The interviews and field notes were scanned for themes, which were then coded. For example, the women’s interviews were examined for themes and all references to ‘paid work’ or ‘abortion method’ were placed into sub-units that were then read across the hermeneutic units. I used SPSS software (SPSS Inc., 2001) to calculate numerical data gained from the medical records review and create statistical analyses. Charts and graphs were generated from SPSS or Excel software (Microsoft Corporation, 2000).
FINDINGS

The medical records of women with post-abortion complications during 2001 show at least a quarter were self-induced and a third had five or more pregnancies, which was a health risk in itself. The vast majority of women were married and a third of the women experiencing an abortion had no children while 12% had four or more children. The women used many methods to end their pregnancy including self-medication with Western and Burmese medicines, vigorous pelvic pummeling and insertion of objects into the sex organs, which increased efficacy but also danger. Figure 1 shows the combined in-patient and out-patient departments at the Mae Tao Clinic alone treated 467 women for post-abortion complications. Mae Tao Clinic does not offer abortion on request but treats the complications arising from spontaneous abortions (miscarriages) and unsafe induced abortions, both of which can be life threatening. Post-abortion complications formed a large part of the work performed by the Burmese health workers in the reproductive health departments. Births at the Mae Tao Clinic increased dramatically due to an increase in the number of beds available to women and more comfortable conditions in the reproductive health in-patient department.
The records at the Mae Sot General hospital showed 31 Burmese women were referred from the Mae Tao Clinic to the local Thai public hospital for post-abortion care during 2001. These women were sicker than other women or not responding to the available treatment given at the Mae Tao Clinic. The cost of 116 days of post-abortion care in the hospital for these 31 women was 71,432 Baht ($US 1,903), which was 2,300 Baht ($US 61) per woman on average. As the majority of Burmese women in Thailand earn less than 3,000 Baht ($US 80) a month this gives an indication of the financial burden on women and their families. The Mae Tao Clinic carried the economic costs of cases their staff referred to the Thai hospital but other self-referred undocumented migrant workers paid their own bill. In 2001, there were 360 records of post-abortion treatment at the Thai public hospital, most of which were for...
Burmese women. Three-quarters of the women stayed three days or less for post-abortion treatment and some women required life-saving treatment such as blood transfusions, antibiotics and surgery.

Not all women survived. The medical casenotes held at the Mae Sot General hospital recorded 14 maternal mortality related deaths during a two-year period. Data from the Ministry of Health show that in Tak province maternal mortality is low. In 2001 three women died, in 2000 one woman died, in 1999 no women died, in 1998, one woman died and in 1997 two women were recorded as dying (Ministry of Public Health, 2003). This discrepancy occurred because the Thai national system only counts Thai citizens. This is not a conspiracy against Burmese women but their deaths go unnoticed by the public health system and by the Union of Myanmar.

Figure 2 Causes of 14 cases of maternal mortality in the Mae Sot General Hospital during 2001 to 2002

There is often no autopsy or coroner’s inquest into their deaths, however I used a verbal autopsy method with the senior obstetrician in order to clarify the cause
of death and we found that 3 women died due to abortion complications. Of the 14 dead women, 2 were Hmong (hilltribe) and 12 Burmese. No Thai woman died during the two-year period in this hospital. Most of the women died within twenty-four hours of admission to hospital and their casenotes showed considerable efforts on the part of the Thai staff to revive them. Many came too late and in very poor condition to the hospital.

Lack of quality community based contraceptive services

Family planning with modern methods of contraception has the potential to save lives, particularly for women who do not desire a pregnancy. The Thai public hospital did not offer a range of temporary contraceptive methods to women who were in-patients immediately after a natural or induced abortion; instead staff asked women to return to the hospital six weeks after the abortion to talk about family planning options. As it is possible to get pregnant within two weeks of any kind of abortion or miscarriage this policy is inadequate (World Health Organization 2000). Table 1 shows that the majority of Burmese women received no modern method of contraception on discharge and three were sterilised. Sterilisation was the only method offered to Burmese women while they were in-patients and this is not an option for many young women with incomplete families. Language and cultural barriers between Thai staff and Burmese patients also made counselling, education and consent difficult. In contrast, the Mae Tao Clinic offered contraception counselling and supplies to women while they were still in-patients and nearly all women accepted a method at discharge, a third of which included sterilisation. Out of 43 women, only 3 directly declined to use contraception. One woman did not need a contraceptive method as her husband died in a motor vehicle accident, which had prompted her to abort her pregnancy.
Table 1  Post-abortion contraception offered to Burmese women by place of discharge

<table>
<thead>
<tr>
<th>Method of contraception</th>
<th>Mae Sot General Hospital In-patient (17 women)</th>
<th>Mae Tao Clinic In-patient (26 women)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing offered</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Condom</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Depot 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>

There were many traditional methods or local beliefs to control fertility reported by Burmese women and lay midwives. Thirteen female patients from the Mae Tao Clinic produced 19 different ways a woman could control her fertility from ‘asking her husband’, to ‘drinking sugarcane juice, ginger and whiskey’ or ‘go to the lay midwife who will lift the womb’. During interviews, women recalled the names of a few modern methods but did not know how to use them or where to get them. In another listing exercise with fifty community midwives from Karen State in Burma, 16 different traditional methods and 7 modern methods of contraception were elicited. Interestingly they included abortion as a traditional method of fertility control.

Women’s stories of attempted fertility control

Forty-three Burmese women admitted to the Thai public hospital and/ or the Mae Tao Clinic for post-abortion care agreed to be interviewed. Of those women who agreed to be interviewed as they recovered from their pregnancy loss, the youngest was 18 and the oldest 41 years. The average age at marriage was 21 years and most women were in a married or long-term relationship. More than a third of the women
disclosed inducing their abortion on their own or with the help of an abortionist. The majority of women had children already and only 8 had no living children. The characteristics of the women interviewed are very similar to the profiles contained in the medical records held by the outpatient department at the Mae Tao Clinic.

The women spoke of the poor economic conditions in Burma, the military regime’s burdensome taxation and forced labour that prompted the move to Thailand. Other migrant workers disclosed their persecution due to political or religious reasons. A twenty-five year old woman from Mon State with an unsafe induced abortion, which resulted in a pelvic infection and intestinal obstruction, talked about her reasons for leaving Burma and her employment situation in Thailand.

I came to Thailand because the economic situation in Burma is very bad. I work here as a farm hand and we grow roses, fruit and vegetables. I live outside of the town in a rural village. 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 ($US 1.86 – 2.66). I never had fever before, now I have chills- it is like malaria but it is because I am bleeding. This time when I was pregnant, I went to end my pregnancy with the lay midwife because my female boss didn’t want me to be pregnant. She shouted at me and swore at me that I would lose my job.

Workers without work permits can be arrested and deported by Thai police, so women were reluctant to travel to any type of health service and often waited until they were very unwell. But having a work permit did not necessarily offer protection as there was scrutiny to ensure women were not pregnant at the time of a permit’s issue, and some employers pressured women to end their pregnancies (Naridsa Suksanan 2002). Due to poverty and unregulated work environments women felt coerced to terminate their pregnancies.
While some women aborted without their husband’s knowledge or consent, other women discussed their situation with their husband and they made the decision to abort the pregnancy together. A 24-year-old husband talks 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 walk 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.

Women’s right to work for equal pay, right to work during a pregnancy or any notions of maternity leave is non-existent for Burmese workers in Thailand. As most women interviewed did not have a work permit, they were a particularly vulnerable population.

In this study domestic violence appeared in several Burmese women’s accounts of their motivation to end the pregnancy. As domestic violence is a relatively common experience for many women in South East Asia (Manderson & Bennett, 2003), the female research assistant asked about violence in the following way – ‘How is your relationship with the father of your child(ren)?’ and ‘Do you ever feel scared of him?’ These two questions elicited evidence of emotional and physical domestic violence. Five women out of 43 reported surviving various forms of
domestic violence ranging from emotional abuse to violent beatings. Three out of ten men disclosed controlling, threatening and beating their wives to the male research assistant. Violence may directly cause some abortions and make other women feel that they do not want to form a family and rely on violent men.

The Burmese and Thai health workers never reported domestic violence in the medical casenotes but women were willing to talk about their relationships. This thirty-eight year old Muslim woman who induced her own abortion with a bamboo stick spoke of her abuse:

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 am scared of my husband…he scares me a lot. I worry when he is drunk and that he will hit me… I give up on husbands and I don’t want any more babies. I want to look after the one’s 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.

This was the only case we found of a woman inserting an object into her body by herself as most asked a lay midwife for assistance. Although we did not ask directly if women had experienced forced sex, this woman’s account of not being able to decline sex when she menstruated or when she felt there was not enough privacy is important. Other women talked of their duty to please their husband or their fear of him finding another woman if they refused sex too often. This also implies some coercion in sexual relationships and an unequal power dynamic.
Women were determined to end their pregnancies despite restrictions and barriers. A woman described her unsafe induced abortion where she crossed into Burma and returned to Thailand for post-abortion care.

I have been pregnant three times now. I lost two pregnancies. I have a young daughter. Before I had a miscarriage at one month and this time I went to Burma to get an abortion. I didn’t know it would be like this and so painful. My friends didn’t tell me that there could be a problem. They took me to her place in Burma. I did this because I did not want the baby and our economic situation is not good. I crossed over the river and went to the Burmese side with my friends. I went to the abortionist. She doesn’t do deliveries – if you give her money she will do an abortion. She seems a very nice woman. I asked her how much should I pay? It was 5,000 Kyats (350 Baht or $US 9.32). 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 a 6 cm stick into me… 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 tummy 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 that night, the pain was very bad and I couldn’t stand it so my husband took me to the Clinic.

This account was the most graphic collected on the method and duration of the stick abortion technique, a painful test of endurance. At the time of this interview, the national border between Thailand and Burma was closed but she managed to navigate her way through. This twenty-six year old married Burman woman spent two weeks hospitalised in Thailand due to a foreign object in her uterus, two tubal-ovarian abscesses and a blood infection. Her fertility is most probably compromised irreversibly.
CONCLUSIONS

Refugees and migrant workers from Burma are among the most marginalised people in Thailand and therefore face the greatest health risks. The maternal deaths of Burmese women are underreported and the rate of induced abortion is underestimated. Women face particular problems concerning unwanted pregnancies and often attempt to terminate their pregnancy. They face pressures from husbands, employers and poverty to abort. I also found domestic violence caused some women to want to end their pregnancy. The general insecurity of the area and restrictions on travel exacerbate the problem. The inaccessibility or low quality reproductive health services available to women mean that they are often unable to find a positive health outcome or practice preventative health measures with effective contraception. Furthermore, the difference in languages and culture erect barriers to understanding and trust between Thai health workers and women from Burma. Women resort to their own traditional or local knowledge that is not always effective and sometimes very dangerous. There is little reproductive security in Thailand for Burmese women and the pressure on women from many sources to be economically productive but not reproductive in Thailand is strong.

While the Royal Thai Government does spend money on the health of people from Burma, they also reap the economic rewards of cheap labour. There is a need to be more creative in the delivery of health care, for example, placing bi-cultural workers in Thai public health services to assist Thai staff to communicate with their patients and providing information and supplies for women while they are still inpatients. In this area, community outreach programmes to factories, farms and meeting points would be effective, but need to be supported by Thai authorities.
Modern methods of family planning are acceptable to Burmese women if offered at the time of need and in culturally appropriate ways. The Mae Tao Clinic is a unique model of refugee led primary health care that provides quality post-abortion care to refugee-migrant workers. Moreover, the legal threats against ending an unwanted pregnancy cause women to seek out dangerous methods and unqualified abortionists. Where women have access to legal, clean and skilled abortion, women rarely die and for others their fertility remains intact. Unfortunately, as stated by Whittaker (2004) ideology rather than public health and the interests of women dominate this debate in Thailand.

ACKNOWLEDGEMENTS

This research was conducted for the doctoral study *Borders of Fertility: Unwanted pregnancy and fertility management by Burmese women in Thailand*. I wish to thank Dr Andrea Whittaker for her supervisory role and Dr Cynthia Maung for her participation and support. I also acknowledge institutional and financial assistance from the University of Melbourne.
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