

Fertility and abortion: Burmese women's health on the Thai-Burma border

by Suzanne Belton and Cynthia Maung

Burmese women in Thailand are pressured from many sources to be productive but not reproductive.

In Thailand's Tak province there are 60,520 registered migrant workers and an estimated 150,000 unregistered migrant workers from Burma. Fleeing the social and political problems engulfing Burma, they are mostly employed in farming, garment making, domestic service, sex and construction industries. There is also a significant number of Burmese living in camps. Despite Thailand's developed public health system and infrastructure, 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.

The research on which this article is based focuses on the mixed flow of migrant workers and refugees in Thailand. Some reside in camps. Those outside the camps have least resource to services and are therefore the most vulnerable. The distinction between 'migrant worker' and 'refugee' is not at all clear. In addition, Thailand is not a signatory to the Refugee Convention and 'refugee' is not an official status in Thailand, whether in camp or not.

Unwanted pregnancies and the lack of access to contraception are major public health issues in Burma. The Myanmar health department (Myanmar is the name adopted by the military regime) ranks abortion in their top ten health problems for the country and the third main cause of

illness. The estimated maternal mortality is 255/100,000 and 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.¹ For displaced Burmese women or those who live in remote areas, the estimated maternal mortality doubles which reflects in part their lack of access to health services and their marginality in relation to the Myanmar state. In Burma it is only possible to obtain a legal abortion if the woman's life is in danger, while slightly less restrictively in Thailand, induced abortion is sanctioned to saving the woman's life as well as in cases of proven rape or incest. Thai women's maternal mortality is far lower than that of Burmese women.

Modern methods of contraception are not widely used in Burma. UNFPA estimates 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. These findings indicate an unmet need for fertility control which women meet by their own local knowledge. Although few studies have examined abortion issues for migrant workers in Thailand, the Thai health ministry has recorded a rate of abortion 2.4 times higher than that of the local Thai population. Many are performed by untrained abortionists and lay midwives.

Health services available to Burmese women

There are limited health services for migrant workers and for those refugees living outside of camps. Many migrant workers in the Tak

province utilise the Burmese-led primary health service called Mae Tao Clinic. This refugee-directed clinic was established by exiled Burmese university students shortly after the 1988 democracy movement. The clinic does not support elective abortion but does provide post-abortion care and family planning services. The staff speak a variety of languages from Burma and many have similar life histories to their patients. The clinic provides a valuable health service that relieves some pressure on the Thai public health services and has been generally tolerated over the past 15 years.

Burmese refugees and migrant workers in Mae Sot also visit the local Thai public hospital and private clinics and pharmacies. Women in the market are additional sources of health information and service. The quality and accessibility of these services varies. If a Burmese migrant has a work permit, they may travel and use the universal health insurance scheme but the climate of fear and uncertainty can stop people travelling. Public transport must pass through many road blocks and checks and if passengers are discovered not to have the correct papers they are deported. While the hospital, private and public health clinic provide care of quite good quality the cost, language and cultural barriers pose problems. The medicine and advice available in the local market is often out of date and of dubious quality.

How can a woman control her fertility?

Abortion and sexual health issues are particularly difficult to research due to the associated stigma and criminal status. This is especially the case when some of the lay midwives are not only 'illegal' visitors in Thailand but carry out activities banned by Thai law. Research methods included

a retrospective review of 185 reproductive health out-patient medical records from the Mae Tao Clinic and 31 records of women transferred to the Thai public hospital for in-patient care. Further information was collected by semi-structured interviews with 43 Burmese women in-patients receiving post-abortion care and 10 of their husbands. Group discussions with Burmese traditional and modern health workers, husbands and community members were also conducted during 2002. Some informants were also asked to generate a list of answers to the open-ended question, 'How can a woman control her fertility?' Very few women receiving post-abortion care declined to be interviewed by the female interviewers.

Key findings from the research show that:

- Post-abortion care at Thai and Burmese health facilities takes large amounts of health resources.
- At least a quarter of women with post-abortion complications have self-induced abortions.
- 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.
- Most women and lay midwives classified menstrual regulation and abortion as traditional methods of fertility control.
- 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 Western and Burmese medicines, drinking ginger and whisky, vigorous pelvic pummelling and insertion of objects into the sex organs.
- Women are pressured by employers, husbands and fear of unemployment to end their pregnancies.
- Some women report domestic violence as influencing their decision to abort.
- Temporary contraceptive information or methods are not offered to women during post-abortion care in the Thai hospital.
- Most women accepted a diverse range of temporary and permanent contraceptive methods from

the Mae Tao Clinic staff while they were still in-patients.

- While women referred from the Mae Tao Clinic to the local Thai public hospital for post-abortion care have their treatment paid for from clinic funds, other self-referred undocumented migrant workers must pay their own bills, which are a large debt burden. (Refugees referred from camps do not have to pay.)
- 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 mortality statistics at a national level so the deaths of Burmese women go unnoticed, by both Thai and Myanmar authorities.

Conclusions

Refugees and migrant workers are among the most marginalised people in Thailand² and therefore face the greatest health risks. Women have particular problems concerning unwanted pregnancies and often attempt to terminate their pregnancy. The general insecurity of the area and restrictions on travel exacerbate the problem. Women resort to their own traditional or local knowledge which is not always effective and sometimes dangerous. There is little reproductive security in Thailand for Burmese women and the pressure on women from many sources to be productive but not reproductive in Thailand is strong. The local policy implications are:

- Modern methods of family planning are acceptable if offered at the time of need and in culturally appropriate ways.
- Burmese workers with knowledge of Thai culture should be placed in public health facilities to assist local Thai staff to communicate with Burmese patients and provide contraceptive information and supplies to

women while they are still in-patients.

- The Thai government should facilitate community outreach programmes to factories, farms and meeting points where refugees and migrant workers congregate.

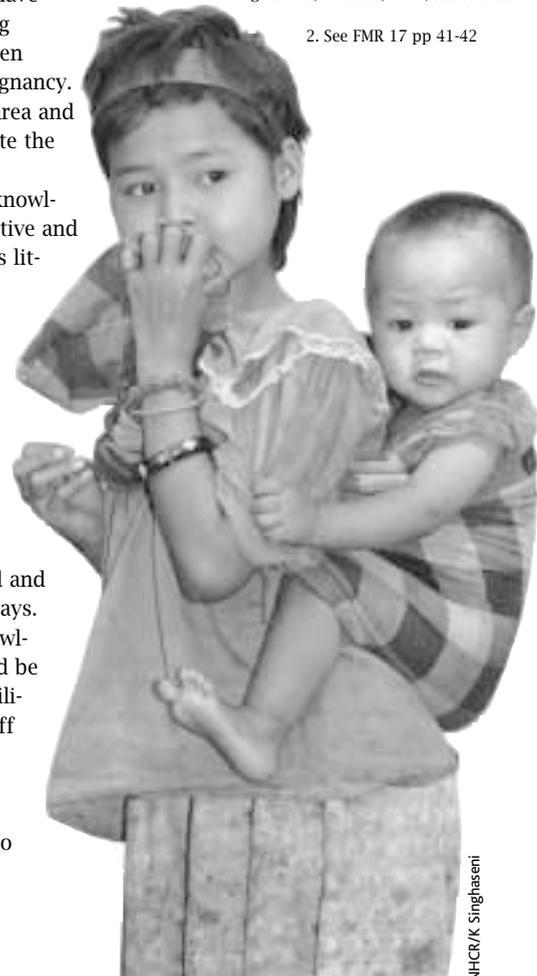
These findings may be applicable to other similar situations where there are large undocumented flows of forced migrants, where work conditions are unregulated, access to health services difficult and elective abortion highly restricted.

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1. Ba-Thike K. Abortion: A Public Health Problem in Myanmar, *Reproductive Health Matters* 9 (May): 94-100. 1997. www.hsph.harvard.edu/grhf-asia/suchana/9999/rh141.html

2. See FMR 17 pp 41-42



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