

Thai-Burma Border Reproductive Health Assessment



Women's Commission for Refugee Women and Children



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Printed in the United States of America

MISSION STATEMENT

The Women's Commission for Refugee Women and Children works to improve the lives and defend the rights of refugee and internally displaced women, children and adolescents. We advocate for their inclusion and participation in programs of humanitarian assistance and protection. We provide technical expertise and policy advice to donors and organizations that work with refugees and the displaced. We make recommendations to policymakers based on rigorous research and information gathered on fact-finding missions. We join with refugee women, children and adolescents to ensure that their voices are heard from the community level to the highest councils of government and international organizations. We do this in the conviction that their empowerment is the surest route to the greater well-being of all forcibly displaced people. Founded in 1989, the Women's Commission is an independent affiliate of the International Rescue Committee.

ACKNOWLEDGMENTS

This report was authored by Sally Girvin, consultant, Sandra Krause, director, reproductive health program and Julia Matthews, former senior technical advisor, Women's Commission for Refugee Women and Children. It was reviewed by Kristen Graham, American Refugee Committee, Dr. Cynthia Maung, Mae Tao Clinic, and Dr. Rose McGready, Shoklo Malaria Research Unit. It was edited by Diana Quick, director of communications, Sarah Chynoweth, program manager, reproductive health program, and Megan McKenna, senior coordinator, media and communications.

The Women's Commission would like to thank the refugees, forced migrants and others living in refugee-like circumstances, representatives of the Committee for the Coordination of Services to Displaced Persons particularly the health subcommittee and other international and local nongovernmental organizations working with displaced populations on the Thai-Burma border, without whose support this report would not be possible.

Cover photo: Sandra Krause

Acronyms

AIMBP	HIV/AIDS Initiative for Mobile and Border Populations
AMI	Aide Medicale Internationale
ANC	Antenatal care
ARC	American Refugee Committee
ARCM	Asian Research Center for Migration
ARHNG	Adolescent Reproductive Health Networking Group
ASRH	Adolescent Sexual and Reproductive Health
AZT	Zidovudine
BBC	Burma Border Consortium
BBG	Burma Border Guidelines
BHPC	Border Health Projects Committee
BMA	Burmese Medical Association
BPHWT	Backpack health worker teams
CBO	Community-based organization
CCMH	Coordinating Center for Migration Health
CCSDPT	Committee for the Coordination of Displaced Persons
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHE	Community health educator
COERR	Catholic Office for Emergency Relief and Refugees
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CSW	Commercial sex worker
DOW	Doctors of the World
EC	Emergency contraception
EmOC	Emergency obstetric care
FHI	Family Health International
FSW	Female sex worker
GAATW	Global Alliance Against Trafficking in Women
GBV	Gender-based violence
HI	Handicap International
HRW	Human Rights Watch
HV	Home visitors
ICBL	International Campaign to Ban Landmines
ICCPR	International Covenant on Civil and Political Rights
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IDU	Injecting drug user
IEC	Information, education and communication
IMPACT	Implementing AIDS Prevention and CARE
IOM	International Organization for Migrations
IPPA	International Planned Parenthood Association
IPPCR	International Convention on Civil and Political Rights
IRC	International Rescue Committee
IUD	Intrauterine device
JAP	Joint action plan
JRS	Jesuit Refugee Service
KAP	Knowledge attitude practice
KEWG	Karen HIV/AIDS Education Working Group
KnED	Karenni National Education Department
KnHD	Karenni National Health Department
KnRC	Karenni National Refugee Committee
KNU	Karen National Union
KnWO	Karenni National Women's Organization
KnYO	Karenni National Youth Organization
KRC	Karen Refugee Committee
KRCH	Kwai River Christian Hospital

KRWGD	Karen Refugee Camps Women's Development Group
KWO	Karen Women's Organization
KYO	Karen Youth Organization
MAP	Migrant Action Program
MCH	Maternal and Child Health
MHD	Malteser Germany
MHP	Migrant Health Project
MISP	Minimum Initial Service Package of reproductive health
MMR	Maternal mortality rate
MOI	Ministry of Interior
MOPH	Ministry of Public Health
MSF	Médecins San Frontières
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
NHEC	National Health and Education Committee
NLD	National League for Democracy
PAC	Post-abortion care
PATH	Program for Appropriate Technology in Health
PE	Peer educator
PHC	Primary health care
PHO	Provincial health officer
PID	Pelvic inflammatory disease
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PPAT	Planned Parenthood Association of Thailand
RCH	Reproductive and community health
RH	Reproductive health
RI	Refugees International
RHRC	Reproductive Health Response in Conflict Consortium
SAW	Social Action for Women
SLORC	State Law and Order Restoration Council
SMRU	Shoklo Malaria Research Unit
SPDC	State Peace and Development Council
STIs	Sexually transmitted infections
SWAN	Shan Women's Action Network
TA	Technical advisor
TALC	Teaching Aid Low Cost
TB	Tuberculosis
TBA	Traditional birth attendant
TYAP	Thai Youth AIDS Prevention Project
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
USCRI	United States Committee for Refugees and Immigrants
VCT	Voluntary counseling and testing
VHV	Village health volunteer
WEAVE	Women's Education for Advancement & Empowerment
WLB	Women's League of Burma
WV	World Vision
ZOA	Dutch for Zuid (South) Oost (East) Azie (Asia),

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Executive Summary

Burma, also known as Myanmar, is one of the most ethnically diverse countries in the world. Since gaining independence from Britain in 1948, it has experienced extreme civil unrest, rooted in the opposition of its various ethnic groups to the military government. The Burmese military's campaign against the ethnic minority groups encompasses a range of abuses, including confiscating cash and goods, forced labor, forced relocation and burning of villages and crops, torture, rape and other forms of sexual harassment and arbitrary executions. As a result, millions of people have fled to neighboring countries or have become internally displaced persons (IDPs) in their own country.

An estimated 600,000 to 1 million Burmese were internally displaced at the end of 2003. Over half a million Burmese refugees and asylum seekers were living in neighboring countries, the majority in Thailand. In addition, hundreds of thousands of other Burmese deemed illegal migrants in Thailand live in refugee-like circumstances¹ throughout Thailand, at least a quarter of a million of whom are suspected to have fled human rights violations. Some 2,000 to 3,000 Burmese continued to cross the border into Thailand each month in 2002.

The Burmese who flee to Thailand, primarily Karen, Karenni, Mon and Shan people, as well as pro-democracy activists, live either in one of nine refugee camps along the border area, or are dispersed along the Thai border across from their respective states in Burma. Most are not registered or documented with the Thai government and are generally subject to harassment and deportation.

The Thai government is not a signatory to the 1951 United Nations (UN) Convention relating to the Status of Refugees nor the 1967 Protocol, and thus does not officially recognize the Burmese as refugees. However, Thailand is subject to other international human rights conventions it has signed, obligating the government to ensure a range of human rights for all people—including refugees. Although the Thai government has provided temporary protection to more than 100,000 refugees in camps along the Burma border since 1984, it also has violated refugee standards by forcing large numbers of refugees back over the border, rejecting new arrivals and deporting individuals who have a valid fear of persecution if they are returned to Burma.

Life for most migrants and other people living in refugee-like circumstances seeking a means of survival in Thailand is an ongoing hardship. They lack support to meet their basic survival needs, including potable water, sanitation and shelter, as well as other human rights, such as education and health. These difficulties are exacerbated by their illegal status and lack of documentation, which also subject them to harassment, extortion, gender-based violence (GBV), arrest and deportation. Those migrants who work are often employed in manufacturing, agriculture, the sex industry and construction for very low wages, particularly women. Children do not usually have an opportunity to attend secondary school; education is often interrupted when parents are arrested and deported.

Refugees living in the nine camps along the Thai-Burma border are provided basic security, access to shelter, sanitation, food, water and health care. The situation for IDPs in Burma is the most destitute in terms of needs and the dearth of services available to them.

These differences significantly impact the reproductive health (RH) care services available to each group.

In general, health conditions in Burma are poor. Major health problems include malaria, tuberculosis, malnutrition and infant and maternal death. Large numbers of people are disabled because of landmine and war injuries. The health situation of IDPs in Burma is particularly poor. Some hospitals and clinics are located in IDP-populated areas, but they cannot serve all in need of care and they tend to lack medicines and laboratory facilities. Limited health services are provided in ethnic minority areas of the Thai-Burma

¹ The Burmese living in "refugee-like" circumstances are those that have fled their country for reasons of persecution but do not have official refugee status for protection and assistance in Thailand.

border by a few in-country organizations and by 70 Backpack Health Worker Teams (BPHWTs) – comprising two medical assistants and a traditional birth attendant (TBA).

Major and critical gaps in RH programming for IDP populations in Burma include a lack of HIV/AIDS education, condoms, voluntary counseling and testing, treatment and care for persons living with HIV/AIDS. A high percentage of induced abortions among IDP women reflect the unmet need for contraception. In addition, there is a lack of trained health workers and supplies for emergency obstetric care (EmOC). Early marriage and adolescent pregnancy are common. Finally, adequate supplies and financial resources to meet the needs of the IDP population in Burma are severely lacking.

Over all, health in Thailand for Thai nationals is generally much better than health in Burma although health indicators for ethnic hill-tribe people have not kept pace with those for Thai nationals. Thailand has made significant progress in reducing infant mortality, improving immunization rates and increasing life expectancy.

Health for Burmese inside the Thai border is potentially improved with the availability of services and water and sanitation. However, the Ministry of Public Health reports that only 16 percent of migrants have access to clean water and less than 50 percent have access to sanitation. Thai hospitals on the border provide emergency care for all patients crossing their borders and hospital doors even if they are unable to pay for the care. This practice adversely affects district budgets that are based on the numbers of Thai citizens and registered migrants in each district.

Since 2000, significant efforts have been made and progress achieved in reaching the hundreds of thousands of migrants and people living in refugee-like circumstances on the Thai-Burma border with primary health care (PHC), including RH. However, health care is not systematically available to migrants and others living in refugee-like circumstances, resulting in poor health outcomes.

Many Burmese migrants and others living in refugee-like circumstances have had no prior sexual or RH education and know little about basic RH anatomy, and physiology and behaviors to safeguard their RH.

Among the most vulnerable are adolescents, particularly girls, who have sought, or been sent by families, to work in Thailand to meet their families' survival needs in Burma, and often have been unknowingly trafficked from Burma to sex work in Thailand.

Health services for refugees in the camps are provided by local and international nongovernmental organizations (NGOs). The most common diseases for the border area camps are respiratory tract infection, diarrheal diseases and skin infections and, in some places, malaria. Immunization programs have become well established in the camps with standard coverage above 90 percent in most camps. Chronic malnutrition has been identified in some camps.

Since the formation of both the Reproductive Health for Refugees Consortium (RHRC) in 1995 (renamed the Reproductive Health Response in Conflict Consortium) and the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Situations leading to the creation of the *Inter-agency Field Manual on Reproductive Health in Refugee Situations*, standards of care for RH are now established and services continue to evolve. The four main components of RH to be addressed in refugee and other displaced population settings are: safe motherhood, including EmOC; family planning; sexually transmitted infections (STIs), including HIV/AIDS, and GBV. Much progress has been made in addressing many of these key RH issues over the last 10 years in the Thai-Burma border camps, yet much remains to be done.

In general, safe motherhood services are good, with high antenatal coverage and most deliveries attended by a trained attendant. In addition, EmOC is available in most sites 24 hours a day, seven days a week. Although a range of family planning options is available, cultural constraints and lack of awareness among the population keep user rates low. The newer technical areas of STIs/HIV/AIDS (with the exception of comprehensive HIV/AIDS programming in Mae La camp) and GBV are the least developed of the services available in the Thai border camps.

Key Recommendations

The key recommendations include recommendations for all population subgroups, including IDPs, migrants and camp-based refugees. Comprehensive recommendations for each population subgroup are available at the end of this report.

All Subgroups (IDPs, Migrants and Camp-based Refugees)

General

International, national and local organizations should work together to support comprehensive education for ethnic community leaders about RH and gain their support for condom availability, for all men, women and youth, not just married couples, to prevent the transmission of STI/HIV/AIDS and to address other controversial RH issues, such as adolescent RH and emergency contraception (EC).

All organizations including: community groups and leaders, local and international NGOs, Ministry of Public Health (MOPH) and UN agencies should increase coordination and collaboration at all levels to support the provision of RH services to migrants, refugees and IDPs in Burma.

One organization should establish an RH task force representing community groups and other local, national and international organizations to collaboratively establish standard RH protocols and a training curriculum; and conduct training workshops on RH education and services including clinical care, adolescent RH and program monitoring and evaluation.

All organizations should seek to increase funding for RH services.

Safe Motherhood

All agencies working in the health sector should ensure that there is a clear system for referral of emergency obstetric patients with the capacity for health workers to provide basic EmOC to stabilize patients prior to transporting them to a referral hospital. The referral hospital should have an adequate number of competent staff and sufficient materials and supplies to provide comprehensive EmOC (basic EmOC plus blood transfusions and cesarean sections) 24 hours per day, seven days per week. A new resource, *Field-friendly Guide to Integrate EmOC into Humanitarian Programs*, is available in English at www.rhrc.org.

Family Planning

All agencies working in the health sector should increase awareness of family planning methods and do appropriate follow-up with all users and defaulters to ensure women and men are satisfied with their choice of method and have not stopped using contraception due to side effects, misunderstanding of use or other reasons that could be addressed.

Local and international organizations should inform women of the availability of EC for rape survivors, as well as for a back-up method when a regular contraceptive method fails or a contraceptive method is not used. A new resource, *Emergency Contraception for Conflict-Affected Settings: A Reproductive Health Response in Conflict Consortium Distance Learning Module*, is available in English and Burmese at www.rhrc.org.

STI/HIV/AIDS

All agencies working in the health sector should ensure that their staff are adhering to standard guidelines for the prevention and treatment of STIs. A new resource, *Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings* developed by the Women's Commission on behalf of the RHRC Consortium, is also available at www.rhrc.org.

All agencies working in the health sector should provide care and support to people living with HIV/AIDS (PLWHA).

All agencies working in the health sector should continue to train their staff on HIV prevention, treatment and care guidelines. Two new, important resources are: 1) the International Rescue Committee's (IRC) *Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations* and 2) *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers* developed by the Women's Commission on behalf of the RHRC Consortium available at www.rhrc.org.

Gender-based Violence

All health workers should provide clinical care for women who have survived rape, including EC and post-exposure prophylaxis for HIV/AIDS. Please refer to *Guidelines on the Clinical Management of Rape Survivors* (WHO/UNHCR 2002) available at www.rhrc.org.

United Nations High Commissioner for Refugees (UNHCR), donors and international organizations should increase funding and technical support to local NGOs to increase their capacity to provide medical, psychosocial and legal care for survivors of GBV and to support education about human rights. Additional support is needed for safe houses, job skills training, education and income generation opportunities for women and girls who have survived GBV, including rape, sexual exploitation, commercial sex work and trafficking. New GBV technical resources include: *Guidelines for Prevention and Response: Sexual and Gender-based Violence against Refugees, Returnees and Internally Displaced Persons* (UNHCR, 2003); *GBV Tools Manual for Program Assessment, Design, Monitoring and Evaluation*, and *Communication Skills in Working with Survivors of Gender-based Violence: A Five-Day Training Curriculum*, both produced by the Women's Commission on behalf of the RHRC Consortium and available at www.rhrc.org.

Adolescents

All agencies should ensure that adolescents are involved in the assessment, design, implementation and evaluation of services and activities for young people.

All agencies should work with community members to improve RH services for adolescents that are acceptable to the community.

All agencies should advocate to camp leaders, Thai authorities and others for pregnant and married adolescents to continue their education in school.

All agencies should ensure girls have access to sanitary supplies.

All agencies should either implement or support youth organizations to provide programs such as peer education, life skills development and vocational training.

Male Involvement

All agencies should work to involve men in health education and outreach efforts to gain their support for emergency referral and transport of women suffering complications of pregnancy and childbirth, birth spacing for healthier families and STI/HIV/AIDS and GBV prevention and response.

The Women's Commission has compiled an extensive bibliography of resources pertaining to reproductive health issues on the Thai-Burma border. The bibliography is available at

http://www.womenscommission.org/pdf/th_biblio.pdf

or at

http://www.rhrc.org/pdf/thai_burma_nov04.pdf

Background

Burma, also known as Myanmar, is one of the most ethnically diverse countries in the world. Since gaining independence from Britain in 1948, Burma has experienced extreme civil unrest rooted in the opposition from its various ethnic groups to the central military government.² Burma has been controlled by an oppressive military regime since 1962, which has driven the country into political isolation and economic disarray. The current regime, the State Peace and Development Council (SPDC), took control in 1988 when it was known as the State Law and Order Restoration Council (SLORC)³ and immediately began a campaign of killing, imprisonment, persecution and torture, initially focused on members of the pro-democracy movement. In 1990, after elections were held, the regime refused to hand over power to the National League for Democracy (NLD) following that party's landslide political victory. It continues to harass NLD members and to detain the leader of the pro-democracy movement, Daw Aung Sun Suu Kyi, until the present day.

The government expanded targets of its human rights abuses to the ethnic minority groups that comprise one-third of the country's population under the pretext of maintaining national unity, although its true aim was to gain control of the areas occupied by these ethnic minorities.⁴ Although cease-fires have been brokered with some ethnic groups, many groups persist in their struggle to obtain some political and economic power over their lives. Some cease-fire agreements resulted in minimal fighting, fewer deaths and more opportunity for travel, trade and local initiatives for villagers. However, rather than decreasing its presence in the region as expected, the Burmese military has increased the number of its battalions, with the military taking land for housing and agriculture to support the troops, thus violating the land rights of the local villagers.⁵ Ethnic minority groups, having been disenfranchised politically and economically and losing many of their social, cultural and religious rights, accuse the government of discrimination and an intentional policy of "Burmanization."⁶ The Burmese military's campaign against the ethnic minority groups encompasses a range of abuses: confiscating cash and goods; forced labor, including the use of human landmine sweepers; forced relocation and burning of villages and crops; torture; rape and other forms of sexual violence; and arbitrary executions. As a result, millions of people have fled to neighboring countries or have become internally displaced persons (IDPs) in their own country.⁷

The Women's Commission conducted its first reproductive health (RH) assessment on the Thai-Burma border in 1994 as part of a global evaluation to determine what types of RH services were available to refugees and IDPs worldwide. At that time, the majority of services on the Thai-Burma border were limited to skeletal maternal and child health (MCH) services and there was little attention to more comprehensive RH such as sexually transmitted infections (STIs), including HIV/AIDS, or gender-based violence (GBV).⁸

Over the past decade, the Women's Commission has continued its attention to the border through supporting capacity building of local organizations as well as making more assessment visits to inform its advocacy efforts. In this 2003 assessment, the Women's Commission took a comprehensive approach to gather and synthesize the numerous studies that have been conducted by local and international agencies in recent years on refugees as well as migrants working and living on the Thai-Burma border. The Women's Commission hopes that this report and its accompanying annotated bibliography will serve as a resource for other researchers on the border, identify remaining gaps in RH services and research needs, and be a source of information sharing among the many actors working in the region.

2 International Crisis Group, *Myanmar Background: Ethnic Minority Politics*, ICG Asia Report No. 52, (May 7, 2003).

3 SLORC changed its name to SPDC in 1997.

4 National Coalition Government of the Union of Burma (Border Office), *Internally Displaced Persons Situation in Burma*, 2003.

5 Ashley South, Researcher, BBC meeting, Bangkok, Thailand, June 11, 2003.

6 International Crisis Group, *Myanmar Background: Ethnic Minority Politics*, ICG Asia Report No. 52, (May 7, 2003).

7 Ibid.

8 Women's Commission for Refugee Women and Children, *Refugee Women and Reproductive Health Care: Reassessing Priorities*, (June, 1994).

Burmese Refugees

Because it is difficult to assess the number of people on the move under such harsh circumstances and near isolation, reports vary as to how many people have fled their homes and homeland. According to the United States Committee for Refugees (USCR)⁹, between 600,000 and one million Burmese were internally displaced at the end of 2003. Over half a million Burmese refugees and asylum seekers were living in neighboring countries, including Thailand, China, India, Malaysia and Bangladesh. Thailand hosted 335,000 refugees and asylum seekers, almost all from Burma, with 133,000 ethnic Karen and Karenni living in camps; 50,000, mostly Karen, living outside camps; 150,000 Shan dispersed among the local population; and approximately 1,400 Burmese refugees recognized by the United Nations High Commissioner for Refugees (UNHCR).¹⁰ USCR notes up to two million other Burmese live in “refugee-like” circumstances throughout Thailand, at least a quarter of a million of whom are suspected to have fled human rights violations. Some 2,000 to 3,000 Burmese continued to cross the border into Thailand each month in 2002. In addition, the Burmese Refugee Committee estimates 300,000 ethnic Shan fleeing forced relocation in Shan state live in Thailand and cannot be accessed by UNHCR, which most likely would consider them *prima facie* refugees.¹¹

The internally displaced (within Burma) are primarily ethnic minorities, Karen, Karenni, Mon and Shan, although some are Burmese who have been relocated from cities or villages. IDPs are forced into relocation centers where the military attempts to cut off the ethnic opposition armies from food, financial support, communications and recruits (a policy known as “the four cuts”). Those who have fled relocation sites or other persecution often live in remote jungle areas where they must forage for food, endure a lack of potable water, battle illnesses, such as malaria and HIV/AIDS without the benefit of basic health services, struggle with drug addiction and subsist in the midst of serious poverty, insecurity and danger from Burmese armed forces.¹²

In one study of the migrant population living in Chiang Mai, Thailand, nearly half of the respondents (96 percent of whom were of Shan ethnicity) reported being forced from their homes, while 80 percent reported forced labor and 47 percent reported being forced to work as porters for the Burmese military. In the same study of the migrant population in Ranong, 16 percent of the respondents, primarily of Dawai, Burmese and Mon ethnicities, reported forced displacement and 92 percent reported forced labor or portage for the Burmese military.¹³ United Nations (UN) efforts are tightly controlled by the Burmese government¹⁴ and humanitarian access remains limited with the exception of a few cross-border aid programs that provide emergency food and medical care to a small number of the internally displaced.

Burma has not ratified the UN 1951 Convention or the 1967 Protocol related to the Status of Refugees. However, the SPDC did ratify the Convention on the Rights of the Child (CRC) in 1991, which prohibits GBV against children, and the Convention on the Elimination of Violence Against Women (CEDAW) in 1998, which forbids all practices and policies that discriminate against women, including GBV.¹⁵ Burma has not signed onto numerous international treaties, including the International Convention on Civil and Political Rights (ICCPR), the Convention Against Torture, the Geneva Convention relative to the Protection of Civilian Persons in Times of War and its Additional Protocol; however, many of these

9 The United States Committee for Refugees changed its name to United States Committee for Refugees and Immigrants in 2004. At the time this research was carried out, it was known as U.S. Committee for Refugees.

10 U.S. Committee for Refugees, *World Refugee Survey*, (2004).

11 Refugees are recognized on a *prima facie* basis (i.e. without the need for further proof) when there is a general assumption that conditions are objectively dangerous in their country of origin. They are afforded protection accordingly.

12 Women’s Commission for Refugee Women and Children, *Nowhere to Run: Ethnic Burmese Living in Refugee-like Circumstances in Thailand*, (February 2000).

13 Therese Caouette, Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, Institute for Population and Social Research, Mahidol University, (2000).

14 Global IDP Project, *A Global Overview of Internal Displacement by the End of 2002*, (February 2003).

15 Refugees International, *No Safe Place: Burma’s Army and the Rape of Ethnic Women*, Betsy Apple, Esq. and Veronika Martin, (April 2003).

provisions are accepted as part of customary international law, and are violated by state-sponsored rape.¹⁶

Life in Thailand: The Host Country Context

The Burmese who flee to Thailand, primarily Karen, Karenni, Mon and Shan people, as well as pro-democracy activists, live either in one of nine¹⁷ refugee camps along the border area, or are dispersed along the Thailand border across from their respective states in Burma. Most are not registered or documented with the Thai government, and generally are subject to chastisement and deportation.

Human Rights Instruments

The Thai government, which is not a signatory to the 1951 UN Convention relating to the Status of Refugees nor the 1967 Protocol, and thus does not officially recognize the Burmese as refugees, allows specific assistance to be provided in the camps by nongovernmental organizations (NGOs) for “people of concern” (direct survivors of conflict, as determined by the Thai government). This makes it difficult for ethnic minorities to claim protection in Thailand because of the Thai government’s position that only those fleeing direct fighting are granted temporary leave inside the country.¹⁸ By not signing the international conventions, the Thai government avoids direct involvement by UN agencies and does not jeopardize its relationship with the Burmese government, an association that benefits Thailand in the form of cheap labor and trade. However, Thailand is subject to other international human rights conventions it has signed, including the ICCPR, the CRC, and CEDAW.¹⁹ These treaties obligate signatories to ensure a range of human rights for all people—including refugees—such as the right to liberty and security (ICCPR, article 9), freedom from arbitrary expulsion (ICCPR, article 13), women’s fundamental rights on a basis of equality with men (CEDAW, article 3), registration immediately after birth (CRC, article 7) and health rights (CRC, article 24). In addition, the Thai government must also respect customary international law and, as a member of UNHCR’s Executive Committee, must abide by the principle of *non-refoulement*.²⁰ (The UN General Assembly adopted by consensus a resolution on the human rights situation in Burma, “expressing grave concern at...rapes and other forms of sexual violence carried out by members of armed forces” and the “disproportionate suffering of members of ethnic minorities, women and children from such violations.”²¹) There is no regional refugee instrument in Asia (as exists in Africa and Latin America) and Thailand’s only domestic legislation states that undocumented asylum-seekers are “illegal migrants” and thus may be deported.

The UN Special Rapporteur on Human Rights for Burma, Professor Sergio Pinheiro, visited the country in October 2002, challenged the SPDC on the reports of systematic rape of women by the Burmese military in Shan state and recommended an investigation into these human rights abuses in the border area.²²

Thailand’s history of recognizing refugees from Laos, Vietnam and Cambodia has soured its stance on providing protection to Burmese refugees because the government saw its policies as attracting refugees who otherwise might not apply for asylum if its policies were more restrictive. By not internationalizing the refugee issue, the Thai government can more easily escape responsibility for the Burmese refugees

16 Ibid.

17 In August and September 2002, Karenni Camp 3 was relocated to Karenni Camp 2, per an unexpected decision by the Thai authorities (BBC, 2002).

18 Human Rights Watch, *Unwanted and Unprotected: Burmese Refugees in Thailand*, (September 1998).

19 Ibid.

20 Article 33 of the 1951 UN Convention states that a refugee shall not be expelled or returned by a contracting state to the frontiers of territories where his life or freedom would be threatened on account of race, religion, nationality, membership of a particular social group or political opinion.

21 Refugees International, *No Safe Place: Burma’s Army and the Rape of Ethnic Women*, Apple and Martin, (April 2003).

22 Burmese Border Consortium, Relief Program Report for the Period July to December 2002.

residing in its country. Although the Thai government has provided temporary protection to over 100,000 refugees in camps along the Burma border since 1984, it also has violated refugee standards by forcing large numbers of refugees back over the border, rejecting new arrivals and deporting individuals who have a valid fear of persecution upon their return to Burma.²³

The Role of UN Agencies

UNHCR began its work in Thailand in 1977 with a regional representative in Bangkok, followed by a downgrading of the office in 1983 to a branch office. In 1997, it once again became a regional office.²⁴ In 1998, under a new Thai administration, UNHCR was granted a formal protection role (observer status) and greater presence in Thailand to assist Burmese refugees, primarily in the camps.²⁵ In 2004, UNHCR tried to gain access to Burma's eastern border areas to be prepared in case cease-fire agreements were reached between the SPDC and fighting factions, and the voluntary return of some Karen, Karenni and Mon refugees could be possible.²⁶

According to UNHCR's Thailand 2004 country report, current relations between Thailand and Burma are positive and expected to continue to improve. The Thai government is predicted to pursue repatriation of refugees to Myanmar to so-called "safe areas," not places of origin. UNHCR noted that repatriation would be contingent upon conditions being suitable for a safe and dignified return, including an improved political situation in Myanmar, amnesty for refugees, and UNHCR's access to monitor repatriation and return on both sides of the border. In addition, UNHCR continues to establish a permanent presence in the refugee camps. Refugees continue to be known as "displaced persons" and camps are called "temporary shelters."

Provincial Admission Boards involved in refugee status determination have become inactive in the past two years, a government policy that discourages further camp registration. UNHCR continues to advocate for camps located close to the border to be moved to safer locations; no cross-border attacks have been reported recently but past attacks highlight this serious protection issue. UNHCR estimates that there are 300,000 ethnic Shan living along the border; UNHCR does not have access to them and they are not allowed into the camps, which are mostly occupied by Karen and Karenni ethnic minorities. The ethnic Shan live in Thailand as migrants, as the Thai government has denied the Shan "refugee-type" services, such as those offered by the Burmese Border Consortium (BBC). Ethnic minorities, particularly the Shan, are typically labeled as economic migrants. The Thai government states that admission to the country is only for those "fleeing fighting" whereas UNHCR advocates for a broader definition that includes persons "fleeing the consequences of fighting," such as forced labor, forced relocation, excessive taxation, physical violence and other human rights abuses. Finally, UNHCR observes that the number of refugees applying for asylum has steadily increased in the past two years as a consequence of the Thai authorities making large-scale arrests of political dissidents from Burma.

UNHCR does manage a restricted determination process but due to the Thai government's position it uses the term "person of concern" rather than "refugee." Previously, refugees living in camps along the border were known in Thai terminology as "temporarily displaced" people; the camps were not called "refugee camps" and camp residents were not recognized as *prima facie* refugees until 1993. UNHCR's limited role in assisting Burmese refugees has generally acceded to the Thai government's categorization of two Burmese groups: students who fled the 1988 uprising and whose claims of political persecution were accepted and ethnic minorities who were deemed to be only "temporarily displaced."

23 Human Rights Watch, *Unwanted and Unprotected: Burmese Refugees in Thailand*, (September 1998).

24 Ibid.

25 Women's Commission for Refugee Women and Children, *Fear and Hope: Displaced Burmese Women in Burma and Thailand*, (March 2000), and Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings, Country profiles Burma/Thailand*, Ward, J., (April 2002).

26 UNHCR, Country Operations Plan, Myanmar, 2004. Accessed January 9, 2004 at <http://www.unhcr.ch/cgi-bin/texis/vtx/home/opendoc.pdf>.

UNHCR is not capable of providing sufficient protection to Burmese refugees due to four reasons: 1) UNHCR's limited definition of a refugee; 2) an inadequate system of documentation; 3) UNHCR's inability to prevent deportations; and 4) the Thai government's interference in UNHCR procedures.²⁷ Human Rights Watch also cites examples of UNHCR not complying with its own procedures for determining refugee status, for instance, not stating in rejection letters the reason for rejection, making an appeal difficult.

The United Nations Children's Fund's (UNICEF) Thailand office does not have a long history of working in emergencies but is trying to step up its efforts based on the global push in 1998 for UNICEF to be more involved in emergency situations.²⁸ There is hesitation in working with displaced people in Thailand due to the political situation. UNICEF does not have a presence on the border, but does manage two projects. The first is a regional data collection project looking at children affected by armed conflict in Thailand, Indonesia and the Philippines. UNICEF regional and national offices are working with Chulalongkorn University in Bangkok to collect first-hand data using five different types of methodology which are being developed regionally among the three country partners. The project is funded by the UNICEF regional office; and the activities are primarily carried out by the university, as a research partner, which is hiring local researchers to conduct interviews, some of which are conducted by the youth themselves. The objective is to use the data to inform advocacy efforts and program implementation and to encourage UNICEF's Thailand office to focus its efforts on the refugee and migrant populations. The second project focuses on child protection, education and psychosocial response.

In 2003, the Ministry of the Interior (MOI) was supposed to initiate the requirement that all camp schools teach at least one hour of Thai in order to promote the acculturation of the Burmese to Thai culture. In addition, UNHCR and the MOI have started using computers to track and register the Burmese to provide identification cards and better track the overall population.²⁹

According to UNHCR, as of February 2003, camp populations on the Thai-Burma border ranged from 3,000 to 32,350 and were nearly equally made up of men and women. Karen, Karenni and Mon ethnic groups were the main camp residents. The BBC, in formal collaboration with the Thai government and per the regulations of the Ministry of Interior, provides food and relief supplies (e.g., blankets, bed nets, etc.), the array of which has increased over the past few years as the refugees have become more aid-dependent, due to increasing restrictions on their mobility and a decreasing ability to work and earn money.³⁰ The lack of official status of the Burmese can pose problems for agencies wanting to provide services to this population, such as the United Nations Population Fund (UNFPA), which is not permitted to fund programs for non-Thai citizens, while other donors only support people who have been granted official refugee status.³¹ In some of the camps refugee organizations actively promote education and capacity building efforts, such as the Karen Women's Organization (KWO), which works to empower women and maintain the Karen culture through women's literacy, leadership, income generation and community care projects.³² In addition, the Women's League of Burma (WLB) comprises 11 Burmese women's organizations of different ethnic backgrounds and works for the empowerment, advancement and participation of women in all spheres of society.³³

27 Human Rights Watch, *Unwanted and Unprotected: Burmese Refugees in Thailand*, (September 1998).

28 Victor Nylund, Emergency Planning Officer, UNICEF, regional office covering 14 countries, including Thailand office, telephone interview, Bangkok, Thailand, June 12, 2003.

29 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T., (October 2002).

30 Burmese Border Consortium, Relief Program Report for the Period July to December 2002.

31 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T., (October 2002).

32 Karen Women's Organization, Empowerment, *Equality, Freedom, annual report*, (2001).

33 Women's League of Burma (WLB) members are: All Burma Democratic Lushai Women's Organization, Burmese Women's Union, Chin Women's Organization, Kachin Women's Association/Thailand, Karen Women's Organization, Lahu Women's Organization, Pa-O Women's Union, Rakhine Women's Union, Shan Women's Action Network, Tavoy Women's Union and Women's Rights and Welfare Association of Burma.

International organizations supporting local organizations also face problems involving the political nature of the local organizations. For example, supporting the camps means that international organizations could be seen as supporting Burmese ethnic rebel groups.³⁴

Migrants

Life for most migrants seeking a means of survival in Thailand—and for some compelled to provide additional support for families struggling in Burma—is an ongoing hardship, starting with the fact that they are not afforded adequate protection status and support to meet their basic survival needs, including potable water, sanitation, shelter and other human rights, such as education and health.^{35, 36} Their difficulties in Thailand are further exacerbated by their illegal status and lack of documentation, which also subjects them to harassment, extortion, GBV, arrest and deportation, although documentation does not always prevent these human rights abuses.³⁷ For most, life is constricted and circumscribed by fear. Burmese migrants often leave fundamental social and cultural supports in Burma, further compounding their precarious situation.³⁸ Those migrants who work are often employed in manufacturing, agriculture, the sex industry and construction for very low wages, particularly women, due to gender inequality in pay.³⁹ Employers often want to keep the workers close to them to facilitate production and because of the risks of arrest for their illegal employees. Thus, migrant workers often live in and around factories in crowded open dormitory style or in temporary illegal structures at the backside of communities or in slums.⁴⁰ Representatives of local organizations and members of the community themselves report that this oppressive and dehumanizing situation has created a sense of powerlessness and hopelessness resulting in depression, substance abuse and domestic violence.⁴¹

Although some unofficial primary schools are struggling to remain open year by year with meager resources, children do not usually have an opportunity to attend secondary school, and education for children is interrupted when their parents are arrested and deported.⁴²

The Thai government allowed the registration of previously undocumented Burmese workers first in 1996, but the majority of migrants did not come forward, owing to the unaffordable registration fees and fears of job loss and deportation.⁴³ According to the Ministry of Public Health (MOPH), 568,000 migrants, including 450,000 Burmese, were registered with work permits and health insurance at a cost of 3,250 baht (US\$75 to US\$80) in 2001. The number of registered migrants declined to 407,630 of a total of 1,222,143 registered and non-registered migrant workers in 2002. The MOPH reports the decline is due in part to the high cost of registration, lack of perceived benefit to registration for migrants and because some migrants are forced to work illegally.⁴⁴

34 Information on Malteser Germany (MHD) activities provided by Marie-Theres Benner, Project Manager, Thailand; Senior Regional Advisor, Interview by report authors, Bangkok, Thailand, June 9, 2003.

35 John Beyrer, Unpublished report, *The Health and Humanitarian Situation of Burmese Populations Along the Thai-Burma Border: A Report on Current Status*, (Johns Hopkins University School of Hygiene and Public Health, 1999).

36 Dr. Cynthia Maung and Tara Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

37 Therese Caouette, Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, Institute for Population and Social Research, (Mahidol University, 2000).

38 Ibid.

39 John Beyer, *The Health and Humanitarian Situation of Burmese Populations Along the Thai-Burma Border: A Report on Current Status*, (Johns Hopkins University School of Hygiene and Public Health, 1999).

40 Dr. Suphot Dendoung, Ministry of Public Health, The Meeting of Development of Health Collaboration, Ranong Province, March 27, 2004.

41 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

42 Ibid.

43 Ibid.

44 Dr. Tares Krassanairawong, Chief, Quality and Health Service System Development, Thai Ministry of Public Health, The Meeting of Development of Health Collaboration, Ranong Province, March 27, 2004.

The humanitarian needs of hundreds of thousands of Burmese living in refugee-like circumstances and others forced to seek a sustainable livelihood in Thailand, some for well over a decade, as well as for the hundreds of new arrivals fleeing Burma each month, have, until recently, been largely ignored save for the courage, leadership and commitment of members of the affected communities through local NGOs, some national and international NGOs, and the benevolence of concerned Thai health officials.

Since 1999, in the wake of an economic downturn, the Thai government has been cracking down on undocumented, and thus, illegal migrant workers in the country, deporting thousands.⁴⁵ In addition, the siege of the Burmese embassy in late 1999, the Ratchaburi hospital siege in January 2000 and the Samut Sakorn prison hostage taking in November 2000 all contributed to the hardening of Thai government policies toward refugees as well as a public perception that refugees are to blame for a range of social ills, including HIV, malaria and drug trafficking.⁴⁶ This crackdown has been bolstered by new regulations that punish employers in addition to migrants for violating immigration law. Those “refugees” arrested will be fingerprinted and catalogued in a computer, then deported back to Burma,⁴⁷ where reports assert that returning migrants processed through the Myawaddy holding center are subject to mandatory HIV testing and the segregation of those who are HIV-positive.⁴⁸ One report noted that 3,000 migrants were deported from Mae Sot, Thailand, to Myawaddy, Burma, and underwent mandatory HIV testing. Twenty migrants testing HIV-positive were separated from their families and communities and sent to a Rangoon hospital. The report noted the violation of the UN HIV Principles and Guidelines adopted by both Thailand and Burma and the false assumption by the Burmese government that HIV is foreign disease being brought into the country from external sources.⁴⁹ Essentially, these people living in refugee-like circumstances experience a never-ending cycle of Thai government crackdowns, arrests, deportations and human rights abuses.

45 CARE Thailand/Raks Thai Foundation, *Migrant Workers and HIV/AIDS Vulnerability Study Thailand*, September 1999.

46 International Rescue Committee, April – December 2000; Final Report, *Reproductive and Child Health, Mae Hong Son Province*. (February 2001).

47 Aung Su Shin, *Burmese Migrants and their Employers Warned*, *The Irrawaddy*, Vol.11, No. 3, May 29, 2003. Accessed at www.irrawaddy.org.

48 Migrant Action Program, et al, *Deportation of Burmese Migrants and HIV Testing*. July 2002. Accessed May 2003 at

[www.http://december18th.net/paper52Burma.htm](http://december18th.net/paper52Burma.htm).

49 Ibid.

The General Health Context

Burma

In general, poor health conditions in Burma exist for the majority of the population, although given the government's tight control on information, health data are either unavailable or unreliable. The 2000 World Health Organization's (WHO) World Health Report labeled the Burmese government's health expenditures and the Burmese people's health status as next to the last (just better than Sierra Leone) out of 192 countries. The UN Working Group on Human Development states that defense spending, as a percentage of GDP, is twice as high as its spending on health and education.⁵⁰ Approximately 35 percent of the population does not have access to any kind of public sector primary health care (PHC) services.⁵¹ Major health problems inside Burma include malaria, tuberculosis, malnutrition and infant and maternal death. Landmine and war injuries result in large numbers of people becoming disabled and toxic substances such as fertilizers and insecticides cause high rates of morbidity and mortality. Immunization rates are reported to be high inside Burma, but many refugees arriving in Thailand have not been immunized.

In regard to RH, Burma has a maternal mortality ratio (MMR) of 402 deaths per 100,000 live births as compared to a MMR of 44 per 100,000 live births in Thailand. Burma has a total fertility rate of 2.86 per woman compared to Thailand at 1.93 births per woman and a contraceptive prevalence rate of 33 percent for any method compared to Thailand at 72 percent.⁵² UNFPA estimates that one-third of pregnancies end in abortion and that unsafe abortions account for half of maternal deaths.⁵³

The 2003 update describes Myanmar as "on the brink of one of the most serious HIV/AIDS epidemics in Asia," emphasizing that it is the only one of the three Asian countries most affected by the epidemic to have rising HIV infection rates. Current prevalence rate among 15- to 49-year-olds is 1.1 to 2.2 percent in the urban areas, indicating a generalized epidemic, with lower rates in the rural regions.⁵⁴ UNAIDS 2002 cites HIV infection among injecting drug users (IDUs) at more than 50 percent, the prevalence rate among female sex workers (FSWs) indicates about a quarter of that population is HIV-positive, and HIV among the military has increased to 1.4 percent. Although HIV patterns in Burma are similar to Thailand, HIV infection rates (in Thailand) seem to have peaked among many populations whereas Burma's rates are still increasing. In addition, Burma is not taking as strong an approach to implement condom use as Thailand did in its "100% condom campaign" showing only an increase to 50 percent by 2000 of consistent condom use among FSWs.

Adolescents are a population of concern due to a two percent HIV prevalence rate, with women under 20 comprising eight percent of maternal deaths, the vulnerability of out-of-school youth to unwanted pregnancies and STIs and the lack of targeted services available to young people.⁵⁵ Although there are reports of a "strong Burmese health care infrastructure," evidence and general consensus conclude that the health care infrastructure is poor, health workers lack skills and training, and service quality is low.⁵⁶

The health situation of some 600,000 to one million IDPs in Burma is particularly poor. Some hospitals and clinics are located in IDP-populated areas, but they cannot serve all in need of care and they tend to lack medicines and laboratory facilities.⁵⁷ Limited health services are provided in ethnic minority areas of

50 National Coalition Government of the Union of Burma, *Memo on Humanitarian Policy Initiative for Burma*, (August, 2002).

51 Ministry of Health Union of Myanmar and United Nations Population Fund, *A Reproductive Health Needs Assessment in Myanmar*, Yangon, 1999.

52 State of the World Population 2003 and United Nations Population Fund Population Reproductive Health Country Profiles: Thailand and Myanmar.

53 UNFPA, Myanmar Report, 2001. United Nations Population Fund Proposed Projects and Programs.

54 UNAIDS, Country Profile: Myanmar, December 2003 Update, accessed January 9, 2004 at http://www.unaids.org/nationalresponse/print_html.asp.

55 UNFPA, Myanmar Report, 2001. United Nations Population Fund Proposed Projects and Programs.

56 National Health and Education Committee and Burma Medical Association, Report on Health Conference (Burma), October 4-7, 2000.

57 Ibid.

the Thai-Burma border by a few in-country organizations and by 70 Backpack Health Worker Teams (BPHWT) comprising two medical assistants and a traditional birth attendant (TBA). The BPHWTs provide preventive and curative health services, at great peril to their own lives from landmine injuries and military attacks, in 15 IDP areas of Burma where government services are not available and international NGOs are not allowed to go. RH, beyond the delivery of babies, which is rarely attended by a skilled attendant, is often overlooked, although the needs are great.⁵⁸

There are eight PHC clinics servicing seven different ethnic groups including: Karen, Kachin, Arakan, Shan Karenni, Mon and Palua. Health workers only recently integrated MCH services that include basic emergency obstetric care (EmOC) and TBA training.

Landmine injuries are also a serious health problem in Burma. According to the International Campaign to Ban Landmines (ICBL), 1,500 individuals sustained landmine injuries in 1999. The International Mine Ban Treaty, which came into force in 1997 and is currently signed by 144 countries, provides a mandate for UN agencies to address the problem. For example, UNHCR cannot repatriate people without an assessment of the landmine situation. In Burma, landmines have been laid to prevent the insurgency from reaching central Burma. Landmines have been laid by government forces as well as insurgency groups. Among the Karen forces, 40 percent of injuries have been inflicted by their own landmines. Most landmine injuries in Burma take place within a half kilometer of the survivors' homes. There is no systematic monitoring of landmine-infested areas and no data collection to determine the number of survivors. Forces say they do inform civilians in the area about the location of landmines; however, in three years of investigation by the ICBL, no landmine survivors were able to say that they had received any type of verbal warning. Of 300 prisoners sent to serve as military porters, only 75 survived to return to prison. Many died by acting as human mine sweepers and others died of malaria. The ICBL has heard reports of "mercy killings," in which people who have stepped on landmines are shot. Military forces justify the killings by saying there is no medical care for survivors' injuries.

Women in Prisons

Aside from that provided by the International Committee of the Red Cross (ICRC), there is little information on the situation of women detained in prisons in Burma. ICRC is not a permanent presence in the detention centers and may visit each center only twice per year. A nurse is always part of the ICRC team that visits detention centers. A female nurse or delegate speaks with women detainees and ICRC advocates for female guards, separate quarters for men and women, and adequate sanitation. Often, these basics are in place. A major concern is access to medical assistance, a major barrier to which is lack of trained staff. Typically, there is only one doctor who comes to the detention center once a month. In regard to RH, women do give birth in prison. There may be female guards but a male prison director is an obstacle to a woman being referred in time for appropriate care. Mothers are allowed to keep their children in prison with them up to the age of six. Problems seen by ICRC include prostitution or "walking in the dark" and young boys being sexually molested. Prisoners are often moved for agricultural/seasonal work in different areas and also to prevent ICRC from speaking to political prisoners. It is not clear whether there are any mechanisms in place to prevent and manage the consequences of GBV.⁵⁹

Thailand

Overall health in Thailand for Thai nationals is generally much better than health in Burma. Thailand, which spends about 6 percent of its GNP on health care (compared to, for example, 3 percent in the Philippines), has made significant progress in reducing infant mortality, improving immunization rates and increasing life expectancy. Inequities in health do persist, especially between urban and rural areas, and a reported 40 percent of the Thai population does not have adequate access to health services. Infant mortality is two times less in Bangkok than in the south, the north or the northeast of the country. The

58 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

59 Markus Geisser, Field Delegate, International Committee for the Red Cross (ICRC), personal interview, Chiang Mai, June 17, 2003.

economic crisis in 2003 impacted heavily on the health of the poor, as the government cut back on health expenditures.⁶⁰

Thailand is often referred to for its success in employing strong political commitment and a multi-sectoral approach to prevent the spread of HIV/AIDS in the country. However, with one in 60 people out of the 62 million population infected and AIDS now the leading cause of death in the country, Thailand is faced with serious socioeconomic and epidemiological consequences.⁶¹ UNAIDS estimates that until the end of 2006, 50,000 people will die from AIDS-related causes annually and 90 percent of the deaths will occur in people aged 20-44 years. Approximately 670,000 people are currently living with HIV; almost 30,000 infections occur each year.⁶² Unfortunately, the Ministry of Health budget to address HIV has decreased since the economic downturn of 1997 and many international donors are no longer contributing to the country. UNAIDS notes that Thailand's current challenge is to rejuvenate HIV prevention efforts, provide care and support to people living with HIV/AIDS and maintain political commitment to address HIV effectively. Access to antiretroviral treatment is limited in Thailand; 10,000 new people are given access each year but continuation of this program depends on the Global Fund to Fight AIDS, Tuberculosis and Malaria.^{63, 64}

Family Health International (FHI) manages the United States Agency for International Development's (USAID) Implementing AIDS Prevention and CARE (IMPACT), an effort to address the global HIV/AIDS epidemic. IMPACT's focus is on filling the gaps, typically targeting marginalized populations, such as men who have sex with men (MSM), injecting drug users (IDU) and commercial sex workers. FHI subcontracts work to an implementing agency to which it provides technical support. FHI has five projects in Thailand: 1) supporting voluntary counseling and testing (VCT) at the Mae Tao Clinic, 2) in partnership with the American Refugee Committee (ARC), conducting an assessment of HIV prevention among members of the uniformed services in Kanchanaburi province, 3) HIV prevention among MSM in Chiang Mai with Program for Appropriate Technology in Health (PATH), 4) targeting IDU in Chiang Rai among the Akha hill tribe minority, and 5) in partnership with PATH, researching risk of HIV among amphetamine users.

60 World Bank Group, *Health and Nutrition in Thailand, Social Policy and Governance in East Asia and the Pacific Region*. No date. Accessed May 2003 at <http://www.worldbank.org/eapsocial/countries/thai/health1.htm>

61 UNAIDS, Country Profile: *Thailand*, (December 2003).

Accessed January 9, 2004 at http://www.unaids.org/nationalresponse/print_html.asp

62 UNAIDS, *Epidemiological Fact Sheets Thailand*, (2002 Update). Accessed May 2003 at www.unaids.org.

63 Information on MHD activities provided by Marie-Theres Benner, Project Manager, Thailand; Senior Regional Advisor, interview by report authors, Bangkok, Thailand, June 9, 2003.

64 The Global Fund to fight AIDS, Tuberculosis and Malaria is a partnership between governments, civil society, the private sector and affected communities. See <http://www.theglobalfund.org/en/>.

Key Population-based Indicators for Burma and Thailand

Indicators	Burma ⁶⁵	Burma - IDPs ⁶⁶	Thailand ⁶⁷
Total Population (millions)	42.9	600,000-1,000,000	65.4
Age 15-24 years	19.8% ⁶⁸	20.5% under 5	18.4% ⁷¹
Age 60 years and over	7.2% ⁶⁹	45% under 15 2% over 65	9% ⁷²
Average Population Growth Rate (2000-2005)	.42%		.87%
Crude Birth Rate	18.11 per 1,000	40 per 1,000	15.7 per 1,000
Crude Death Rate	12.15 per 1,000	21 per 1000	7.02 per 1,000
Infant Mortality Rate	67 per 1,000 live births	122 per 1,000 live births	20 per 1,000 live births
Under Five Mortality Rate	106 per 1,000 live births ⁷⁰		51 per 1,000 live births ⁷³
Life expectancy at birth	female: 63.8 years male: 57.8 years		female: 74.4 years male: 69.7 years
Illiteracy Rate (age 15 and over)	female: 18.6% (2002) male: 10.8% (2002)		female: 9.5% (2002) male: 5.1% (2002)
Male to Female ratio:	99:100	92:100 (typical for conflict-affected populations)	98:100

65 All data from the 2005 CIA World Factbook unless noted otherwise.

66 Thailand Burma Border Association 2003

67 All data from the 2005 CIA World Factbook unless noted otherwise.

68 2002 CIA World Factbook

69 Ibid.

70 UNICEF 2004

71 2002 CIA World Factbook

72 Ibid.

73 UNICEF 2004

Burmese Living in Thailand

Health for Burmese inside the Thai border potentially improves with the availability of services and water and sanitation. However, the MOPH reports that only 16 percent of migrants have access to clean water and less than 50 percent have access to sanitation.⁷⁴

The MOPH underwent a reorganization in 2002 which resulted in the establishment of three clusters: the Medical Services Development cluster; Public Health Development cluster; and Health Service Support cluster. While border health responsibility remains in the Office of the Permanent Secretary, some border activities fall with the Public Health Development cluster under the Department of Disease Control, and migration is addressed under the Health Services Support cluster.⁷⁵

In 2001, the Thai government established a new health insurance scheme that included outpatient and inpatient care with prescribed essential medicines for 30 baht (70 US cents) per visit at a registered PHC unit and referral to secondary and tertiary care, excluding emergency referrals, dental care, health promotion and disease prevention.⁷⁶ Only registered migrant workers, a small fraction of the migrants on the border, are allowed access to Thai health insurance. Most migrants are not registered due to the prohibitive costs for registration, while others are not aware of the health insurance benefit with registration.⁷⁷ Moreover, migrants who can theoretically access services, because they are registered, at the Thai health facilities often do not do so because of language differences, costs, low education and literacy, poor health knowledge, restrictions on movement and fear of arrest and deportation. Location and living situation often determine the degree of access; for example, migrants living in small farm communities have less access to health care than do those living in or near Thai villages.⁷⁸ In a study conducted by Mahidol University among migrants in Chiang Mai, Mahachai and Ranong in 1998, most migrants addressed their health care needs through traditional healers or by purchasing medicine at the local drug store.⁷⁹ In the same study, migrants' health, including RH, was reportedly compromised by a lack of access to health education, including sexual and RH information, and public health services in Burma.⁸⁰

Organizations on the Thai-Burma Border Providing Reproductive Health Care

The critical yet disparate efforts of all of the organizations that work with migrants on this border, particularly local and national organizations, before more recent coordination was initiated, are too numerous to discuss but several organizations along the border stand out.

One laudable early effort to address the needs of this until very recently largely ignored migrant population was undertaken by Dr. Cynthia Maung, a refugee herself, who established the Mae Tao Clinic in Mae Sot, Tak Province in 1989. The Clinic has grown from a small makeshift operation with a few volunteer staff assisting approximately 1,700 patients to a large multi-purpose health center providing health and social services. Today, six physicians, 150 volunteer medical, logistics and administrative staff, 86 intern health workers and approximately 20 to 40 international volunteers, provide vital health and social services to a beneficiary population of approximately 150,000 ethnic Burmese living in refugee-

74 Dr Tares Krassanairawiwong, "The Meeting on Development of Health Collaboration Ranong Province", (Conference Notes, March 27- 28, 2003).

75 Ministry of Public Health, "The Meeting on Development of Health Collaboration Ranong Province", (Conference Notes, March 27- 28, 2003).

76 Ibid.

77 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*. (February 2003).

78 International Rescue Committee, *Preliminary Needs Assessment of Migrant Communities Residing Along the Thailand-Burma Border*, (June 2001).

79 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

80 Ibid.

like circumstances and migrant workers in Thailand. IDPs in Burma undertake the dangerous illegal trip across the border to access health care at the Clinic.

Despite its illegal presence in Thailand, the Mae Tao Clinic is one of the leading organizations on the Thai-Burma border providing critically needed and culturally appropriate health care, including RH services, for refugees and migrants in Thailand and IDPs in Burma. In 2003, the Clinic's volunteer staff provided nearly 83,000 patient care visits from a smattering of continuously upgraded inpatient and outpatient care facilities. The Mae Tao Clinic also provides health services for approximately 16,000 IDPs at two satellite clinics in Burma.

In addition to the Clinic's comprehensive inpatient and outpatient services, Dr. Cynthia and the Clinic's volunteer staff support education and social services, including a primary school and a boarding school for orphaned children. The Clinic also hosts regular extensive training programs for health workers, including clinical training for more than 300 ethnic Burmese health workers who now provide health care in migrant communities along the 2,400 kilometer border, for IDPs in Burma or with international organizations in one of nine refugee camps in Thailand. Dr. Cynthia established and provides biannual training for the BHPWTs working in the IDP areas of Burma.

In Tak province the Clinic works in partnership with a variety of community outreach projects, including childhood immunization programs in collaboration with the Thai Minister of Public Health and site visits to agricultural and factory settings to provide migrant women, men and adolescents health information or care. They also visit brothels to educate young girls about HIV and contraception and occasionally support the payment of a girl's debt bondage to free her from commercial sex work.

In 2000, Dr. Cynthia helped found, and remains on the board of directors of Social Action for Women (SAW). SAW established a 10-bed temporary safe house for abandoned infants and young girls who have suffered GBV or who are seeking to escape commercial sex work or forced prostitution. SAW helps the young girls attend school and provides job skills training. In addition, SAW conducts community outreach and RH education through mobile clinics and by referring migrant workers in factories and agricultural settings to health facilities in the Mae Sot area. SAW also implements RH training programs for TBAs and adolescents.

The Mae Tao Clinic's director and its staff also undertake advocacy on behalf of ethnic Burmese through research, publication of papers and presentations at international conferences. Dr. Cynthia is also actively involved in hosting seminars and participating in ethnic professional associations. For example, she chairs the Burmese Medical Association (BMA) and collaborates with the National Health and Education Committee (NHEC) to develop health systems and policies to ensure the future health care of displaced Burmese people. Under Dr. Cynthia's direction, the Clinic has received numerous international accolades for its compassionate and courageous work in addressing the health and human rights of forced migrants in Thailand and the internally displaced in Burma. Among them are the Jonathan Mann Health and Human Rights award, the John Humphries Award and the prestigious Magsaysay award.

Shoklo Malaria Research Unit (SMRU), also based in Mae Sot, has been steadfastly committed since 1986 to good quality malaria screening, diagnosis and treatment to prevent further drug resistance in an area noted for the world's most resistant malaria parasite, Plasmodium Falciparum. SMRU's programs include training, technical assistance and research to address: malaria in pregnancy and infancy; malaria control and treatment studies; nutrition and anemia; laboratory studies; entomology; antimalarial drug treatment and thiamine depletion, including effects on pregnancy outcomes; HIV/AIDS awareness and prevention of vertical transmission. SMRU has also established significant antenatal care and safe motherhood programs in refugee camps and migrant communities to help mitigate the high risk of malaria for pregnant women.⁸¹ Safe motherhood including EmOC was established in the camps where SMRU worked in 1986. Antenatal care in migrant pregnant women with identification of women at risk for delivery complications commenced in 1998. SMRU has worked in close collaboration with the Karen HIV/AIDS Education working group (KEWG) since 1996 on HIV/AIDS/STI education in the camps. Family

⁸¹ Shoklo Malaria Research Unit, „The Meeting on Development of Health Collaboration Ranong Province», (Conference Handout, March 27- 28, 2003).

planning services were provided in Shoklo, Maela and in the migrant communities until they were handed over to Planned Parenthood Association of Thailand (PPAT) in 2000. SMRU and KEWG commenced the prevention of mother-to-child transmission (PMCT) program in Maela Refugee camp in May 2002.

The KWO, which was established in 1949, reviewed its mission and set new goals to empower women in 1985. It is a community-based organization (CBO) of Karen women working in relief and development in the camps along the Thai border and among IDPs in Burma. Its objectives are to empower Karen women, increase women's decision-making at all levels and achieve equality with men. KWO projects are extensive and include: the Karen Young Women's Leadership School, which provides training in community development, politics, environment, women's rights, leadership skills and gender awareness; women's literacy; income generation; equality, freedom and peace building; health and RH, including for adolescents; community care giving, including support for the safe houses in Mae La Camp; mediation of family disputes; coordinating a range of support efforts for new mothers and elderly women; nursery schools; cultural and sports competitions, self-defense training and community gardens. KWO reports that the primary problems for migrants are STIs and HIV/AIDS; rape of women by Burmese and Thai soldiers and employers, which most women are afraid to report to the authorities; and lack of family planning resulting in subsequent unsafe abortion.⁸²

On the northern Thai-Burma border, in Chiang Mai province, a significant initiative is the Migrant Action Program (MAP), established in 1996 to support migrant women's and workers' rights. MAP works closely with the Law Society of Thailand to enforce migrant rights and provides education to migrants to access health, legal and social services.

In collaboration with the Ministry of Public Health and WHO, World Vision (WV) works with Burmese migrants, particularly fisherman and sex workers in Ranong, Mae Sot, Mai Sai and Phuket, and combines this work with cross-border activity in Kawthoeng, Maywaddy and Tachielek in Burma to facilitate communication regarding HIV/AIDS, commercial sex work and trafficking, family planning and MCH projects.

Following its border-wide assessment in 2001, Doctors of the World (DOW) initiated a capacity building project for eight local organizations working on the border in both Burma and Thailand to assist their work with youth to improve their RH. The International Rescue Committee (IRC) conducted needs assessments among migrants and community outreach activities with migrant populations in Mae Sot and Phro Pha districts in Tak province.

One of the key initiatives of the CARE Thailand/Raks Thai Foundation is its capacity building work with a network of 11 NGOs which aims to establish a sustainable health structure for migrant workers through advocacy for policy changes at local and national levels. CARE Thailand/Raks Thai Foundation also supports health care for migrant workers, including seafarers and adolescents, through mobile clinics and peer education programs in collaboration with the Ministry of Health in Ma Ha Chai, Samut Prakan, Samut Sakhorn, Pattani and Rakon provinces. Project outputs include the development of a curriculum to train seafarers in HIV/AIDS, and information, education and communication (IEC) materials such as cartoon books for youth on HIV/AIDS prevention.

The Shan Women's Action Network (SWAN) is a local NGO that addresses the need of the much-neglected Shan population through various projects.⁸³ A Women's Crisis Support Center was established in Chiang Mai in 2001 to help women who have experienced domestic violence, health problems or issues with their employer. In June 2003, the Center housed 28 women and children, overextending the capacity of the house, which is only sufficient for 10 people. SWAN also supports education activities through primary schools. The Thai authorities do not allow SWAN to start secondary schools despite SWAN having at least three students who want to pursue further education. The cost for one year of schooling for one child is 8,000 baht (US\$200). SWAN also supports an education coordinator who

82 Trip notes, meeting with Karen Women's Organization representatives, April 5, 2003.

83 Women's Commission's interview with Shan Women's Action Network (SWAN), Chiang Mai, June 17, 2003.

travels along the border as an outreach/social worker to identify children for school or women in need of assistance.

SWAN supports one clinic in the north called Puang Liang. An internship program is also made available to young women from the border areas who have the opportunity to work in Chiang Mai in return for a small amount of spending money, transport and lodging. They learn about women's issues, political topics, human rights, gender issues, environmental concerns and democracy. SWAN also actively documents the situation of the Shan, including recent reports on domestic and sexual violence, information about their activities and newsletters which help to build awareness within the community. SWAN also works with the NGO WEAVE (Women's Education for Advancement & Empowerment) to develop HIV communication materials, such as posters, as well as a Shan history textbook. Finally, due to the difficulty most Shan have in understanding Thai, SWAN also provides translation, as well as transportation to safe places for Shan to access low-cost health services. SWAN is able to advocate for the patient and explain to health services staff why a person has come from Burma to Thailand and thus needs a discounted price for services.

A one-year-old Shan boy who is from Fang province came to Chiang Mai. He had been sick for three days but the family was afraid to go to the hospital because they are illegal migrants and didn't think they had enough money for the hospital costs. (Employers often keep their employees' work permits so the workers have to get the work permit from the employer to leave the farm.) The mother also had been sick for a long time with tuberculosis. When they finally got to the hospital, they could not speak the language; often the doctors just give them aspirin and send them away. With the help of SWAN, the boy was treated for malaria and his mother finished treatment for TB. We hear stories of nurses calling the police to take away the pregnant women who have come to the hospital for care. I am afraid this might happen in Chiang Mai in the future." SWAN

"You may [apply] for work permit and registration but [this] doesn't automatically give a person health insurance. It is beneficial for Thailand to use migrant labor because they must treat Thai people better with time off and adequate working conditions, holidays. Migrant labor is cheap and people are willing to use pesticides." SWAN

Coordinating Assistance

Information-sharing and coordination activities among the NGO members of the Committee for the Coordination of Displaced Persons (CCSDPT) in Thailand have been in place since 1985; its medical sub-committee is the gatekeeper of health sector plans and activities. There is also evidence in recent years of gradually increased inter-agency coordination and collaboration among and between local, national and international NGOs, as well as the Thai public health sector and civil society and other national institutions regarding the humanitarian needs of camp-based refugees and migrant populations.

In 2000 UNHCR, IRC and the Burmese Border Consortium (BBC) initiated a protection working group and a series of protection workshops were hosted from mid-2000 through 2003. Later, regional protection working groups comprising UNHCR and local and international NGO representatives were established in Mae Hong Son, Mae Sot and Konchonaburi, which meet regularly.

The International Organization for Migration (IOM) and the MOPH established the Coordinating Center for Migration Health (CCMH) to provide coordination and expertise for a Migrant Health Project (MHP) established to improve the health, including RH, of migrant populations by increasing unregistered migrants' access to good quality health services. An inter-ministerial committee called the Border Health Projects Committee (BHPC) provides oversight and monitoring of the project. In 2000, the IOM and WHO, in collaboration with the MOPH, initiated a three-year Joint Action Plan (JAP) to address HIV, tuberculosis and malaria, targeting four major border areas in Chiang Rai, Tak, Kanchanaburi and Ranong provinces.

In addition, in 2001, the Japanese government supported a two-year initiative to facilitate coordination and collaboration among organizations to address the health needs of migrants in 10 provinces. A WHO Border Health Program Officer was posted in Thailand in 2001 for two years. In addition, border-wide health workshops have been hosted annually since 2002 by the MOPH and WHO with significant representation from the MOPH and a variety of local and international NGOs. The objectives of the workshops are to facilitate information sharing among organizations working on the border to improve health outcomes, to distribute technical information, particularly on malaria, HIV/AIDS and tuberculosis, and to identify issues for potential cross-border cooperation among organizations. Among the outcomes and recommendations from the Meeting on Development of Health Collaboration in Ranong Province in March 2003 were recommendations for improving border health coordination, standardizing data collection, mechanisms and utilization of volunteer health workers and developing a standardized medical records book.⁸⁴

Although ethnic Burmese migrant and national NGOs, international NGOs and the MOPH have undertaken a number of PHC initiatives, particularly since 2000, systematic, PHC is not available for migrant populations. A lack of culturally acceptable, accessible and affordable PHC for Burmese migrants is an affront to their human rights and further results in desperately ill migrants in tertiary care centers, where Ministry of Health officials often respond to migrants' needs for critical care. For example, the lack of migrant women's access to family planning results in women suffering the trauma of unwanted pregnancies and unsafe abortion with subsequent referrals to Thai hospitals for expensive emergency obstetric care.

Refugees in the camps are provided health services by local and international NGOs, including the Aide Medicale Internationale (AMI), ARC, IRC, Malteser Germany (MHD), Médecins Sans Frontières (MSF), and SMRU. In at least one instance Thai communities in the Mae Sot area have complained that refugees in Mae La Camp get better services than local citizens.⁸⁵ External refugee camp administration involves the local ethnic refugee communities, international NGOs, the community and camp committees, for example, health and education committees. Internally there are various groups of local organizations like the KWO and the Karen Education Working Group (KEWG).

The most common diseases in the border area camps are respiratory tract infections, diarrheal diseases and skin infections, and in some places, malaria, although malaria is reported to have significantly decreased in the past few years.⁸⁶ Chronic malnutrition has been identified in some camps, becoming apparent when nutrition surveys were conducted by the BBC in 2001 and 2002. The surveys indicate that rations are too high in carbohydrates and lacking in protein, fats and several micronutrients.⁸⁷

Due to restrictions on mobility and work in Thailand, the refugees are no longer able to supplement the camp rations. However, several international organizations have supported extensive garden programs in some of the camps. Plans are underway to change the rations and add a blended mix of micronutrients to the food.⁸⁸ Updated information reveals that a micronutrient enriched flour called the Asia mix has been introduced in all of the camps and the Centers for Disease Control (CDC) are studying the effectiveness of the new mix.

84 Ministry of Health and World Health Organization, „The Meeting on Development of Health Collaboration Ranong Province,, (Program Brief, March 27-28, 2003).

85 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, (Violante, T, October 2002).

86 Nosten F, van Vugt M, Price R, Luxemburger C, Thway KL, Brockman A, et al. *Effects of artesunate-mefloquine combination on incidence of Plasmodium falciparum malaria and mefloquine resistance in western Thailand: a prospective study*. (Lancet 2000; 356:297-302).

87 McGready R, Simpson JA, Cho T, Dubowitz L, Changbumrung S, Bohm V, et al. *Postpartum thiamine deficiency in a Karen displaced population*. *American Journal of Clinical Nutrition* 2001; 74(6):808-81

88 Burmese Border Consortium, Relief Programme report for the period July to December 2002.

The Reproductive Health Context on the Thai-Burma Border

Assessment Methodology

This report is based on desktop research and two site visits conducted by the Women's Commission's Reproductive Health Program Director and Program Manager in three provinces on the Thai-Burma border in the Spring and Summer of 2003: Ranong, Mae Sot and Chiang Mai. The purpose of the assessment was to document progress in RH services, gaps and remaining challenges among refugees and non-camp refugees, Burmese living in refugee-like circumstances and migrants. The Women's Commission also sought to identify, collect, summarize and organize for future reference findings from previous studies and reports addressing components of RH for displaced populations on the Thai-Burma border.

The Women's Commission visited six of nine refugee camps including: Ban Kwai, Ban Mai Nai Soi, Nu Poh, Umpiem Mei, Ban Don Yang and Tham Hin. The Women's Commission also conducted an information interview with the Program Manager working with MHD in Mae Kong Kha camp and received information regarding RH services in Mae La camp and migrant communities from a key representative of SMRU who reviewed and commented on the draft of this report. The assessment team conducted focus group discussions with refugee and migrant women, men, adolescents and leaders utilizing the Reproductive Health Response in Conflict (RHRC) focus group guidelines. The Women's Commission also conducted key interviews with representatives of local and international organizations, United Nations agencies and the Thai Ministry of Health.

While RH conditions inside Burma are unlikely to have improved much since 1994 when RH services were nearly non-existent, services for Burmese living in the camps in Thailand have vastly improved in the last decade as demonstrated by assessments⁸⁹ conducted by the RHRC Consortium⁹⁰ and the Women's Commission for Refugee Women and Children.⁹¹ RH care and access to services are significantly better in the camps and for Thai communities; unfortunately, Burmese migrants and others living in refugee-like circumstances in Thailand do not generally benefit from these improvements. However, assessments have been conducted in the country and an RH strategy has been developed.⁹²

89 Reproductive Health for Refugees Consortium, *Refugees and Reproductive Health Care: The Next Step*, (1997).

90 Formerly known as the Reproductive Health for Refugees Consortium.

91 Women's Commission for Refugee Women and Children, *Fear and Hope: Displaced Burmese Women in Burma and Thailand*, (March 2000).

92 Htay, Thein Thein, et al, *A Strategy for Advancing Reproductive Health in Myanmar*, (Asia-Pacific Population Journal, December 2000).

Key RH Indicators for Burma and Thailand

RH Indicators	Burma	IDPs in Burma	Thailand
Contraceptive Prevalence Rate			
Any method	33%	40.2%	72%
Modern methods	28%		70%
Total Fertility Rate per Woman Age 15-49 years	2.86 births per woman	4.6 births per woman	1.93 births per woman
Age-Specific Fertility Rate, Age 15-20 years	29.4 births per 1,000 women		50.7 births per 1,000 women
Maternal Mortality Ratio	402/100,000 live births		44/100,000 live births
Skilled Delivery Attendance	56%	33%	85%
HIV/AIDS			
Adult prevalence rate	1.99% (1999)*		1.8%
ANC prevalence	2.05%		1.56%
Sex workers prevalence	26-41%		6.7-42.2%
People living with HIV/AIDS	180,000-400,000		670,000
Deaths in 2001	48,000 (1999)*		55,000
General Reproductive Health Indicators from State of the World Population 2003 and United Nations Population Fund Population Reproductive Health Country Profiles: Thailand and Myanmar. HIV/AIDS Indicators from UNAIDS 2002 Update (Sentinel Surveillance). Back Pack Health Worker Team, Reproductive Health Survey 2002 *CIA World Factbook 2002			

With the creation of the *Inter-agency Field Manual on Reproductive Health in Refugee Situations*, standards of care for RH are now established and continue to evolve. The four main components of RH to be addressed in refugee settings are safe motherhood, including EmOC; family planning; STIs, including

HIV/AIDS; and GBV. Adolescents are a population of particular concern. Additionally the Minimum Initial Services Package (MISP) for reproductive health is a package of priority RH activities to be implemented in the initial stages of an emergency setting that aim to reduce maternal and neonatal morbidity and mortality, prevent and manage the consequences of sexual violence and reduce transmission of HIV. The MISP was implemented by ARC during the 1997 emergency phase in the Nu Poh Camp in Tak Province in 1997.⁹³ Much progress has been made in addressing many of these key RH issues on the Thai-Burma border camps, yet much remains to be done.

Many Burmese migrants and others living in refugee-like circumstances have had no prior sexual or RH education and know little about basic RH anatomy and physiology and behaviors to safeguard their RH. Research among migrants in Ranong and Chiang Mai provinces of Thailand indicated that there were critical gaps in the knowledge of the few migrants, primarily males, who were found to have some understanding about sexual and RH. In the same study, young migrant girls were taken by surprise with their first menstruation, and lacking guidance, rely on traditional beliefs and behaviors to cope with this transition in their lives.⁹⁴

Traditional cultural beliefs supported by ethnic minority leaders, such as the belief that condom promotion promotes promiscuity, impede migrants' access to a key intervention to prevent the transmission of HIV/AIDS. One ethnic minority leader expressed his anger about condoms, to a member of the Women's Commission assessment team, stating, "12- to 13-year-olds are too young to know about and use condoms." Migrants are often subsequently unable to take measures to protect themselves from the escalation of life-altering and life-threatening RH problems that befall them.

Among the most vulnerable are adolescents, particularly girls, who have sought, or been sent by families, to work in Thailand to meet their families' survival needs in Burma, and often have been unknowingly trafficked from Burma for sex work in Thailand. Some of these young girls find themselves in immediate debt-bondage to a brothel owner before they understand where they are, and like young women raped at border crossings, face additional and traumatic risks of STI/HIV/AIDS, unwanted pregnancies and unsafe abortions.

RH for the broader refugee community is also addressed by a variety of other organizations. For example, the Health and Education Sub-committees of the CCSDPT in Thailand each meet regularly to discuss specific health issues in camps on the border, relevant protocols and resources. A number of organizations, such as DRUM publications, IRC and WEAVE, maintain catalogues and order forms for resource materials. WEAVE works in Mae Sot, Chiang Mai and in the camps in these areas with Mon, Shan, Burmese, Karen and Karenni refugees. WEAVE also collaborates with Thai clinics, government hospitals, local NGOs like KWO. Aide Médicale International (AMI) publishes in Burmese and English a quarterly distance learning magazine for health workers and their communities called Health Messenger; 7,000 copies of the magazine are distributed, with 50 percent going to camps, 15 percent to migrant workers and 35 percent to Burma. The March 2003 issue focused on RH and provides substantive information on GBV, including social, cultural and medical guidance. The same issue presented guidelines for prevention, assessment and treatment of unsafe abortion; explained how to limit mother-to-child transmission (MTCT) of HIV/AIDS; provided nutrition information for pregnant women; and offered parenting tips. The June 2004 issue focused on HIV and provided practical information for health workers to use in working on HIV issues on the border. While efforts like the Mae Tao Clinic and the Health Messenger do not translate into the routine availability of RH services for all who need them along the Thai-Burma border, they are indicators that RH is becoming a greater priority and illustrate important progress.

93 American Refugee Committee, *Reproductive Health Project Report*. (Nu-Poh Camp, Umphang District, Tak Province, Thailand, February 10-April 15, 1997).

94 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

Reproductive Health Services in General

Safe Motherhood

IDPs in Burma

IDPs face their own unique set of challenges in accessing safe motherhood services. According to the supervisor of the BPHWT, many of the components of safe motherhood are provided in the IDP areas of Burma where the BPHWT has a presence, but some essential components of antenatal and basic EmOC are not available. Antenatal care, including detection of complications, routine malaria care and prevention such as drugs and bed nets, iron and folate prophylaxis, Vitamin A supplementation and antihelminthic treatment are available. However, routine syphilis testing and tetanus toxoid immunization are not available. Clean delivery kits are provided to TBAs and partographs are maintained at the health facilities. While some components of basic EmOC are available, oxytocic drugs are only available in a few areas. Manual vacuum aspiration (MVA), dilation and curettage, and assisted vaginal deliveries (vacuum extraction and forceps) are generally not available, although some mobile clinics have trained health workers. Comprehensive EmOC is not available. Only one mobile clinic area has safe blood transfusion available. Essential newborn care and postpartum services are also barely available. According to the best estimate of the head of the BPHWT, 33 percent of the population has access within two hours to antenatal care, delivery including EmOC and five percent to postpartum care.⁹⁵

A survey of IDP women undertaken by the BPHWT in 2002 indicated that early marriage and adolescent pregnancy are common among ethnic minorities, with more than two-thirds of women married by the age of 20 and nearly half of them having had their first pregnancy at the time. Moreover, one-fifth of women had their first pregnancy by 18 years of age. In addition, while the majority of women (77.7 percent) deliver at home with TBAs, in one setting, up to 25 percent of women reported delivering their child on the run. One-third of women in the BPHWT study also said they had had at least one spontaneous abortion. Ten percent of women reported at least one induced abortion, with 31.8 percent saying they did not know who performed it, just over one-third reporting a TBA carried it out, and 17 percent inducing the abortions themselves. An additional 18 percent of women did not respond to the question or said they did not know. The authors of the study acknowledge the limitations of the induced abortion findings because of religious, legal and cultural influences that result in social ostracism and punishment for women who have abortions and further point out that these influences are likely the reasons for the high percentage of self-induced abortions.⁹⁶

More than one-third of internally displaced women in the 2002 BPHWT survey were not aware of the importance of antenatal care (ANC) and the majority (79.2 percent) was not aware of the warning signs of complications of pregnancy or delivery.⁹⁷ Maternal mortality rates inside Burma are high, at approximately 402 per 100,000 live births, and complications from approximately 2,000 illegal abortions per day, which are often unsafe, contribute up to 50 percent of Burma's maternal mortality. The Alternative Asean Network on Burma (Altsean) reports that perinatal mortality rates among adolescents (46 to 67 per 1,000 live births) are also high.⁹⁸

Some TBAs are known to engage in unsafe practices, such as using non-sterile sharps to cut the umbilical cord and pummeling or pushing on the women's abdomen during delivery, and they often do not have referral facilities to support them when they are beyond their skill level. Health workers, already

⁹⁵ Meeting with Mahn Mahn, supervisor BPHWT, April 8, 2003.

⁹⁶ Backpack Health Worker Team, *Reproductive Health Survey Preliminary Report*, (July-December, 2002).

⁹⁷ Ibid.

⁹⁸ Altsean, *Abused Bargaining Chips: Women's Report Card on Burma*, Altsean, March 2003.

challenged by the security risks and mobility of the population, are also constrained by a lack of adequate supplies and financial resources to provide continuity of care to IDPs.⁹⁹

Mu Khee Lar, an 18-year-old married Karen woman from Burma, walked to the Thai-Burma border to stay with her elderly parents one month before her first baby was born in order to find her husband in Thailand. Mu Khee Lar did not receive antenatal care in Burma or in Thailand. Her healthy baby girl was delivered by a TBA at 12:00 p.m. on January 9, 2003. However, critical problems set in when she suffered a retained placenta and the TBA was unable to assist her. Although the TBA encouraged Mu Khee Lar to go to the Mae Tao Clinic, she resisted because she had never been to the clinic, she did not know where to go and she did not have money to pay for transport to the clinic. Mu Khee Lar's parents went in search of money to pay for the transport and eventually secured 300 baht (US\$7.50). They walked their daughter to the river where they crossed by boat to Thailand. On the other side of the river they paid a driver to take them by car to the clinic. Several hours passed and by the time she reached the clinic she was unconscious and in shock. Clinic staff treated her for shock and transported her to the hospital at 4:15 p.m., where she died six hours later.

Mae Tao Clinic, January 2003

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

Safe motherhood, including EmOC, is one of the basics requirements of health services in any setting. The majority of migrants in a study conducted in Ranong and Chiang Mai provinces reported somewhat serious problems during and after childbirth, with over one-third describing their problems as very serious.¹⁰⁰ CARE Thailand/Raks Thai Foundation representatives noted that while the MOPH obligates registered migrant workers to undergo health screening for infectious diseases, they also screen women who are pregnant, which could result in the denial of a work permit, deterring women from registering. In addition, the representatives reported that while the registration card entitles one to all health services available under the insurance scheme, including preventive services such as antenatal care, only a small percentage of women made antenatal care visits. In addition, some women delivered at home because of their fear of cesarean sections and sterilization.¹⁰¹

The newborn infants of Burmese refugees living in refugee-like circumstances and illegal migrants are not allowed official birth certificates in Thailand. This is in breach of the ICCPR and the CRC, and inconsistent with previous interpretation of Thai law.¹⁰² In addition, international organizations in Thailand have identified the important link between birth registration and vulnerability to trafficking and advocated this finding to the Thai Ministry of Foreign Affairs.¹⁰³ As of June 2004, the Thai government still did not grant citizenship to children of Burmese parents born in Thailand, depriving them of a nationality, opportunities to avail themselves of education, health care and legal status to protect them from exploitation and abuse, and a future filled with practical hope.¹⁰⁴

Abortion is illegal in Thailand except to save the life of the woman or unless she can prove she survived rape or incest. Burmese migrant women view abortion as a traditional method of birth spacing and often lack access to contraception. In Thailand they self-induce abortions or seek abortions from untrained abortionists or lay midwives for a variety of reasons, including to maintain employment, appease spouses and as the only option to end an unwanted pregnancy. Methods of attempted unsafe abortion include taking quack medicine and home remedies from the local market, drinking alcohol, inserting sticks and

99 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

100 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

101 Meeting with CARE/Raks Thai Foundation Staff, February 4, 2003.

102 Sermchaiwong, Karn, International Rescue Committee, unpublished paper, June 20, 2003.

103 Letter to the Minister of Foreign Affairs of the Royal Thai Government, International Labor Organization, Office of the United Nations High Commissioner for Human Rights (OHCHR), UNICEF Thailand, UNESCO, UNHCR, ECPAT, Forum Asia, IRC, Plan Thailand, Save the Children UK, August 2004.

104 Refugees International, *Refugees International Bulletin: Stolen Futures: The Stateless Children of Burmese Asylum Seekers*, June 25, 2004.

other objects in the uterus and severe pelvic pummeling. The results of these extreme measures are reflected in the high number of women presenting at local clinics and Thai hospitals with life-threatening complications of unsafe abortions, such as infection and hemorrhage.¹⁰⁵

In addition, researchers at Mahidol University found that among its study participants in 1998, 17 percent of migrant women with unwanted pregnancies in Chiang Mai and Ranong attempted to obtain an abortion in Burma or Thailand with just over one-half of them attempting this in Burma and just under one-half attempting abortions either on the border or in Thailand. Forty-five percent of all respondents described the attempts as unsuccessful. Forty-four percent of attempted abortions were conducted by TBAs and about one-third were self-induced using traditional and western medicines, alcohol, sticks, rods and uterine massage. The researchers concluded from focus group discussions and in-depth interviews that, “males and females alike explained that the decision to abort was typically because a couple was not yet married, or already had too many children, or was not in a secure political or financial situation. Several noted that a lack of access to, and knowledge about and proper use of, contraceptives prompted many Burmese migrants to resort to abortions as a form of birth control.”¹⁰⁶

Refugees in Camps

One of the elements of safe motherhood rarely mentioned in RH reports in these camps is the subject of abortion, suggesting a difference in the situation of women living in refugee camps and those living outside of camps in refugee-like circumstances and migrants. In Mae La refugee camp, for example, 11.8 percent of 5,000 pregnancies between August 1997 and May 2002 ended in an abortion, reflecting an average statistic. In addition, none of these abortions were the result of cervical interference with a foreign object. However, this does not mean that there are unwanted pregnancies in the camp and induced abortion does not take place with the use of traditional medicines, for example.¹⁰⁷ The findings could reflect the more desperate living conditions of those living in refugee-like circumstances and migrants or that women in the camps have better access to contraception than women in migrant communities.

In the Karen camps of Tak Province, staff of the PPAT have counseled against abortion, even in the case of rape, because it is viewed as a sin.¹⁰⁸ It's possible this perspective conforms with the traditional cultural norms of the communities of this camp, but in practice, prevention of and treatment for unsafe abortion is an important part of safe motherhood efforts (note that 30 to 50 percent of maternal mortality inside Burma is due to complications of abortion) as is documentation of the abortion situation, where possible, to monitor the needs of women in this area.

EmOC and the referral system were reported as problematic in some areas along the border by representatives from referral hospitals and international NGOs. Some international NGO representatives said that the capacity of local staff in the camps to perform basic EmOC is limited because they do not have sufficient opportunities to practice complicated deliveries under the guidance of experienced professionals, particularly given that international NGO staff are not allowed to stay in camps overnight to assist. At one referral hospital the staff complained that women are often referred very late from the camps or not at all in spite of the fact that the delivery and EmOC services are provided free of charge at this hospital. In addition, when refugees do arrive, there is inadequate documentation of their condition, e.g., hemoglobin on admission and the referral information is written in Karen (instead of English or Thai). Hospital staff expressed concern about the refugee health workers' lack of capacity to provide basic EmOC. Finally, once patients do arrive at the referral facility, hospital staff experience language barriers

105 Belton, Suzanne and Maung, Cynthia, Fertility and abortion: Burmese women's health on the Thai-Burma border, *Forced Migration Review*, Issue 19, (January 2004).

106 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

107 Review of Draft Report, Dr Rose McGready, SMRU, October 2005.

108 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T., (October 2002).

and problems identifying relatives of patients. On the other hand, some international NGO representatives complained that the referral hospital did not always have a physician available to provide comprehensive EmOC 24 hours per day, seven days per week, resulting in further referral and life-threatening delays.

Family Planning

IDPs in Burma

In its Women's Report Card on Burma 2003, Altsean reports that family planning services are not available in more than half of the townships in Burma. The BPHWT survey findings indicated that the average IDP women had four to five pregnancies. Approximately 41 percent of women reported they did not want any more children, while 59 percent of them were not currently using contraception.¹⁰⁹ In a study conducted by Mahidol University in 2000, migrants said they were not aware of family planning and did not have access to contraceptive supplies in Burma.¹¹⁰ Among the consequences of the lack of birth spacing services are unwanted pregnancies. In the ethnic minority IDP areas of Burma, some women believe that contraceptive methods are unnatural and may cause infertility, while contraceptive choice is limited to sporadic supplies of temporary modern methods such as pills, Depo-Provera and condoms.¹¹¹

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There are mixed findings with regard to migrants' awareness and use of family planning. For example, in one study in Chiang Mai the overwhelming majority of migrants had heard of oral contraceptives, injectables and condoms and, to a lesser extent, intrauterine devices (IUD), Norplant and sterilization. Ever use of contraceptive pills and injections was 45 percent and 33 percent among these women.¹¹² However, in some migrant settings such as Ranong and Mae Sot provinces, the unmet need for family planning is obvious in reports of girls and women who have suffered from unwanted pregnancy and complications of unsafe abortions. Some have received care for complications of unsafe abortions multiple times. In the Mompiem health clinic in Mae Hong Song province, contraceptive pills and injectables were used equally by Shan women. The Shan village elder asserted that too many young unmarried women were having children.

According to SWAN, a 26-year-old Shan woman living in Shan state had two sons and did not want any more children. However, she told SWAN that she did not want to get sterilized because she thought it would make her weak.

Refugees in Camps

Family planning, used for birth spacing or for limiting the number of children, is offered in camp clinics (contraceptives have been available in some camps since the late 1980s) and most of the local area clinics, although commodities are not consistently available. Initially, family planning was resisted by some groups as efforts to provide it were suspected to be a means of ethnic population control. Family planning and condom use is generally not allowed by the Karenni leadership, especially for those who are not married. Also, in some settings, condoms are available for family planning for married couples, but not as a means of STI/HIV protection without explicitly stating their use as a means of STI/HIV protection.¹¹³

109 Backpack Health Worker Team, *Reproductive Health Survey Preliminary Report*, (July-December, 2002).

110 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Mahidol University, 2000).

111 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

112 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

113 International Rescue Committee, April – December 2000; *Final Report, Reproductive and Child Health, Mae Hong Son Province*, (February 2001).

For those who do use contraception, Depo-Provera, oral contraceptives and condoms are the most commonly accepted methods. Female sterilization is also requested fairly often, although written consent is not always obtained and questions have been raised about whether the refugee women and men truly understand it is a non-reversible, permanent method.¹¹⁴

PPAT initiated family planning programs in Mae La and Umpiem camps in 2000. SMRU subsequently trained midwives in all methods of contraception in 1994 and comprehensive family planning programs were initiated in Mae La camp in 1996 and handed over to PPAT in 2000.¹¹⁵ PPAT has since extended their activities to 10 villages surrounding Mae La camp while hoping to receive additional support to continue expanding their coverage area. PPAT representatives reported that when they first initiated their family planning program in the camps people tended to get married very young and to have many children but they now believe that young people tend to wait. With regard to contraceptive use, the PPAT representatives report that unmarried refugees usually select condoms and pills, and that there are frequent complaints about the side effect of delayed fertility with the use of Depo-Provera. In addition, use of IUDs and Norplant is rare, while there is increased demand for vasectomies and a long waiting list for sterilization procedures for men and women. PPAT provides training to nurses on EC but not to refugees because “adults think that we promote sex among young people” and “there is a danger of unprotected sex.”

WEAVE produced an emergency contraception (EC) brochure a couple of years ago that was supposed to be distributed to local Karen and Karenni health care providers. The leaders stopped distribution and it has not been distributed since.

STI/HIV/AIDS

IDPs in Burma

The HIV situation in Burma can only be speculated on as information is controlled and closely held by the government. Various prevalence studies have resulted in vastly different estimates, ranging from 1 to 3.5 percent of the adult population being infected. Heterosexual transmission, IV drug use and infected blood supplies appear to account for a majority of the transmissions.¹¹⁶ There is evidence that the SPDC is now taking the epidemic seriously.

For IDPs, the BPHWT supervisor reports that universal precautions, syndromic management of STIs and partner notification are practiced in the IDP areas where the BPHWT has access but, importantly, condoms are not provided to prevent the transmission of STIs. Condoms are only available as family planning for married couples. VCT, antiretroviral treatment and home-based care for people living with HIV/AIDS (PLWHA) are not available. Treatment is available for patients with opportunistic infections but preventive treatment for opportunistic infections is not offered. Some community-based AIDS prevention education is conducted. The BPHWT supervisor's best estimate of the population with access within two hours to STI services is 50 percent but access to HIV prevention services it is 5 percent.¹¹⁷ HIV/AIDS prevention education or even condoms are rare.¹¹⁸

114 Centers for Disease Control and Prevention, Division of Reproductive Health and American Refugee Committee, An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand, August 2002.

115 Draft Assessment Report Review, Dr Rose McGready, SMRU, October 2005.

116 Centers for Disease Control and Prevention News Updates, Burma's Leaders Slowly Moving to Combat HIV, San Francisco Chronicle, R. Frankel, April 8, 2003.

117 Meeting with Mahn Mahn, supervisor BPHWT, April 8, 2003.

118 Backpack Health Worker Team, Reproductive Health Survey Preliminary Report, July-December, 2002.

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

STI/HIV/AIDS are important issues for the border area, as everywhere. Both Thailand and Burma have been hit hard by the HIV epidemic. The Thai AIDS control campaign, implemented after an initial period of denial, has been acknowledged as the first in the developing world to “halt the growing incidence of new cases of HIV and to sustain a steady decline.”¹¹⁹

In its 1998 study of migrants, Mahidol University researchers found that while migrants in Chiang Mai and Ranong believe AIDS is an important problem in the community, many do not believe they are at risk of infection and have very little interest in learning more about condoms. The researchers report, “Data from in-depth interviews and focus group discussions strongly suggests that the majority of participants perceived AIDS as a disease confined to a risk group, in this case, sex workers, rather than to sexual behavior.” Their qualitative assessments also revealed that migrants did not discuss or have knowledge about asymptomatic HIV and commonly identified symptoms of STIs as indicative of AIDS, thus believing that people who appeared healthy could not be infected with HIV. Finally, researchers noted, “AIDS continues to conjure fear and stigma for most of the migrant workers. The fear associated with HIV/AIDS is not only fear of contracting and suffering from the disease, but also fear of being stigmatized, discriminated against and bringing shame to oneself and one’s family.”¹²⁰

A study done by CARE Thailand/Raks Thai Foundation in 1999 found that migrants are particularly vulnerable to STIs/HIV because they are excluded from general health information (in great part because they do not speak Thai) and have limited access to treatment of STIs. Studies show that while the migrants know about HIV/AIDS, many have misconceptions about prevention and transmission which is especially concerning since condom use was shown to be low among this population and since some migrants are also involved in risky behaviors such as visiting brothels and using IV drugs.¹²¹ Research in Ranong and Chiang Mai provinces by Mahidol University in 1998 indicates that men often frequent brothels with their friends following a night of drinking, while migrant women are either not aware or open about discussing how common HIV/AIDS is.¹²²

Women who chose to work in the sex industry and those who are trafficked into it against their will are especially vulnerable to STI/HIV/AIDS and their access to condoms is often limited. Brothel owners decide who gets tested for HIV, and sex workers who reach the stage of advanced AIDS are often kicked out with nowhere to go. NGOs, such as EMPOWER, work to support and aid sex workers.¹²³

Mahidol University researchers learned from their 1998 study in Chiang Mai and Ranong that migrants, particularly the Shan, had limited words in their vocabulary to link their symptoms with reproductive tract infections. However, discharge, especially malodorous discharge, and itching were recognized as at least somewhat serious problems by 69 percent of migrants. Burning on urination was known by 97 percent of participants to be associated with an STI. One-quarter of migrants who had difficulty urinating went without treatment, 26 percent sought care from traditional healers, 27 percent received treatment at a health facility and 20 percent sought treatment at a drug store.¹²⁴

Refugees in Camps

119 World Bank Group, Health and Nutrition in Thailand, Social Policy and Governance in East Asia and the Pacific Region. No date. Accessed May 2003 at <http://www.worldbank.org/eapsocial/countries/thai/health1.htm>

120 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

121 CARE Thailand/Raks Thai Foundation, Migrant Workers and HIV/AIDS Vulnerability Study Thailand, September 1999.

122 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

123 Nang Lao Liang Won, *Guidelines on Strategies and Responses to the Needs of Burmese Migrant Women in Thailand*, (Asia Pacific Forum on Women, Law and Development, January, 1999).

124 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

Surveys and anecdotal reports indicate that the refugees in camps are generally aware of STI/HIV/AIDS, but lack familiarity with symptoms and modes of transmission and prevention.¹²⁵ In addition, a physician working with SMRU reports, “despite the high reported [HIV] rates from Burma, Thailand and Mae Tao clinic, the camps have a much lower incidence of STIs due to stronger cultural practices maintained in the camps.” The rare exposure to the reality of STIs, including HIV infection and AIDS, likely contributes to the limited knowledge about these infections. In addition, donor blood has been tested for HIV at least in some stable camp settings since 1994.¹²⁶

Gender-based Violence

IDPs in Burma

Gender-based violence has a long and horrible history for Burma’s ethnic minority women. Rape and other forms of sexual violence are well documented as widespread weapons of war viciously used by the Burmese army against women.^{127, 128} Women flee Burma because they have been raped or to escape being raped and women in flight are often survivors of rape. Rape and other forms of sexual violence have been used as weapons of war by the Burmese army against Burma’s ethnic minority women for more than 50 years and have been integral parts of the SPDC’s campaign to “Burmanize” and subjugate the ethnic minority population. Women tell of rape during flight, in the course of incarceration in military camps, during forced labor and while farming. The Shan Human Rights Foundation and SWAN documented 173 incidents of rape and other forms of sexual violence, involving 625 girls and women, perpetrated by soldiers from 52 different battalions of the Burmese army in the Shan state from 1996 to 2001. Rape survivors are often shunned by their families and communities or flee to Thailand where, due to their illegal status, they have no access to humanitarian aid, may be deported or are often further victimized by trafficking or other forms of exploitation.¹²⁹ The report on abuses against Shan women led to a fact-finding mission by Refugees International (RI) to broaden the scope of the research to other ethnic minority groups and to support and build upon the activities of the Shan groups. From 26 interviews, RI documented 43 cases of rape or attempted rape against women from five different ethnic groups, with 23 confirmed by eyewitness testimony or physical evidence.¹³⁰ RI was unable to verify any case of rape being prosecuted. Most survivors were afraid to report abuses for fear of retaliation and some who did step forward were indeed killed. The issue is taboo among the Burmese people: women who have been raped are seen as “unclean,” men feel impotent to protect their families, and communities are reminded they are oppressed by their country’s own military. The SPDC has refuted the reports of rape against ethnic women and despite the number of international human rights instruments to which it is obligated to comply, no action is expected to be taken to end the widespread violence against women.

Other forms of GBV, such as sexual exploitation, trafficking and domestic violence are also widespread. Women are forced to be silent due to fear of retribution by authorities, and care and support for survivors is largely unavailable.¹³¹

125 International Rescue Committee and the Department of Community Medicine, Faculty of Medicine Chiang Mai University, *A Final Report of Knowledge, Attitudes and Practices: Health Information Survey in Karenni Camps, Mae Hong Son*, (Thailand, 2001).

126 Draft report comments, Dr Rose McGready, SMRU October 2005.

127 Shan Human Rights Foundation and Shan Women’s Action Network, *Licence to Rape: The Burmese military regime’s use of sexual violence in the ongoing war in Shan State, Burma*, (May 2002).

128 Refugees International, *No Safe Place: Burma’s Army and the Rape of Ethnic Women, Apple and Martin*, (April 2003).

129 Shan Human Rights Foundation and Shan Women’s Action Network, *Licence to Rape: The Burmese military regime’s use of sexual violence in the ongoing war in Shan State, Burma*, (May 2002).

130 Refugees International, *No Safe Place: Burma’s Army and the Rape of Ethnic Women, Apple and Martin*, (April 2003).

131 Altsean, *Abused Bargaining Chips: Women’s Report Card on Burma*, (March 2003).

The BPHWT supervisor reports that there are no particular programs in the accessible IDP areas for prevention and response to GBV. However, some psychosocial support may be available and the BPHWT members have received some training. There are medical guidelines in place for responding to incidents of sexual violence but there are no security personnel or protection officers. The best estimated percent of the population with access within two hours to services for rape is 5 percent.¹³²

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

Those who have survived this brutality in Burma and made their way to Thailand are still not safe from GBV. Lack of legal protection for Burmese refugees and migrants contributes to abuse and violence wielded by Thai officials at checkpoints and border crossings, by police and military in and near refugee camps, brothels and detention centers, by Thai citizens in villages and by factory bosses in exploitive work environments. Rape, domestic violence and other forms of sexual and physical abuse are also common among ethnic groups from Burma residing in Thailand.

In addition, during this trip the assessment team learned of two incidents where a Thai woman had recently purchased infants from young Burmese women in the postpartum ward of a health facility for 3,000 baht (approximately US\$75.00) each. A police report was reportedly not filed because the staff were unable to identify the Thai woman.¹³³

In a study conducted in 1998, migrants reported high rates of domestic violence in Thailand and described the lack of external support to intervene. The study also showed that migrants are occasionally forced to marry by family members and others, and that women often seek marriage for protection from GBV.¹³⁴

Trafficking and prostitution is a complex problem in Thailand as underlined by the fact that the total revenue from prostitution in Thailand in 1995 equaled nearly 60 percent of the Thai government's budget for that year.¹³⁵ An inherent problem in halting the sex trafficking problem is that aside from those who profit from it, many rural families depend on the income that women send back from their work in urban centers. It is estimated that in 1998 some 30 million USD were transferred by women working in the sex sector to their families. Also alarming, it is estimated that 80 percent of the commercial sex worker population in northern Thailand is Burmese, with 40,000 Burmese girls and women forced into Thailand's sex industry each year. Of the children trafficked into Thailand across the Burmese and Chinese borders, 70 to 80 percent are girls. The commercial sexual exploitation of children in Thailand is associated with poverty, lack of education and poor social conditions – forcing many adolescents without any education, skills or other alternatives into the industry to help earn money for their families. In one town in Thailand along the Burma border, seven of every ten families have sold at least one daughter into prostitution; young girls command a premium price because it is assumed that they are less likely to be HIV infected.

Burma and Thailand have signed CEDAW, but holding either government accountable to this treaty poses great difficulties. Most women activists on the border do not recognize the military regime in Burma, and Thai law enforcement officers who have perpetrated violence against women in camps or migrant workers rarely face legal consequences for their actions.¹³⁶ According to Lambert and Pickering, despite the lack of accountability for human rights by the state, awareness of human rights has helped women to become more proactive in relation to their community, allowing them to better judge the actions of community leaders from a human rights perspective.

132 Meeting with Mahn Mahn, supervisor BPHWT, April 8, 2003.

133 Trip Notes, Thailand, April 4, 2003.

134 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Mahidol University, 2000).

135 Women's Commission for Refugee Women and Children, *Trafficking in Women and Children, With a Focus on the Thai-Burma Border*, 2003.

136 Lambert, Caroline and Pickering, Sharon, "Domestic Violence on the Thai-Burma Border: International Human Rights Implications," *Forced Migration Review*, May 2003.

Awareness and attention to prevention and response measures for GBV among refugees and migrants on the Thai-Burma border has slowly but steadily progressed in recent years. MAP initiated one of the first community mobilization activities for prevention and response to GBV in refugee and migrant settings in 1999 in response to migrant and refugee women's expressed concerns about GBV. MAP began a series of monthly meetings in Chiang Mai in 1999 for women representatives of refugee and migrant CBOs to discuss GBV issues. The meetings, organized, hosted and chaired by the CBO representatives, facilitated ownership of the GBV problem and capacity building of the CBOs and were subsequently expanded to Mae Sot, Mae Sariang and Mae Hong Son. As participants shared their experiences and delved into specific GBV issues, MAP explored medical and legal recourse for survivors. The series of meetings was followed by GBV training workshops for some 200 migrant and refugee women to develop concrete action steps for providing legal, medical and psychosocial support for survivors of violence. MAP, in collaboration with WEAVE, has developed the Automatic Response Mechanism as a tool for supporting GBV survivors and addressing GBV in camp settings.

Global Alliance Against Traffic in Women (GAATW) works with local organizations to conduct research and training and to publish findings; follow-up activities are developed based on research findings. In 2003, GAATW was launching an RH study of migrants in Mae Sot with Burmese women, in Ranong with Cambodians and in Samu Phrakhan with Laotians, with two researchers working in each project site. An initial qualitative study will examine the attitudes of migrants toward RH, including their attitudes and perceptions as well as their RH practices in their countries of origin. The results will inform the direction of a follow-up quantitative study.

Refugees in Camps

A 2002 study of women in three Karen and Burmese camps found a 20 percent prevalence rate of domestic violence, including verbal, physical and sexual abuse. Seventeen percent of these women sustained a physical injury from the incident. The women preferred that the refugee community, rather than the health care center, manage domestic violence issues.¹³⁷ Thai law tends to favor male perpetrators, so women and girls avoid seeking protection and legal retribution. Repatriation of women to Burma offers more of the same risks of violence.¹³⁸ Culturally, discussion of rape and other forms of sexual violence has historically been taboo.¹³⁹

In 2000 the CCSDPT, UNHCR and BBC established a working group on protection, eventually involving NGOs on the border to promote shared responsibility for protection among humanitarian actors across sectors. The group hosted a series of meetings and workshops over several years with branch protection working groups later established in Chiang Mai, Mae Sariang, Mae Sot and Kanchanaburi to facilitate information sharing, coordination, recommendations and concrete action plans for improving the protection of refugees and migrants. In June 2001, a workshop was held on GBV at which local women's organizations, international NGOs and UNHCR shared their findings on GBV among refugees and migrants and together strategized to respond to the identified needs and gaps on the border. Rape, sexual abuse and exploitation by Thai authorities, domestic violence, discrimination, forced sterilizations, sexual harassment, humiliation, child sexual abuse, trafficking into prostitution and labor and harmful traditional practices were all cited by a UNHCR consultant as occurring in refugee camps along the border. Others also described the lack of women's participation in camp decision-making despite the existence of well-established women's organizations, the lack of solid information and data on GBV partially due to women's shame, fear of reporting and lack of knowledge about GBV and legal recourse. It was also noted that when a response is undertaken, fundamental principles, such as prioritizing the interests of the survivor, offering the opportunity for a same-sex counselor and confidentiality, are not always respected. Workshop participants identified the need to train men, women and youth in counseling skills, gender, women's rights, sex and sexuality, and human rights. Recommendations were made to

137 Centers for Disease Control and Prevention, Division of Reproductive Health, Malteser Germany, American Refugee Committee and Médecins Sans Frontières, *An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand*, (August 2002).

138 Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings, Country profiles Burma/Thailand*, Ward, J., (April 2002).

139 Refugees International, *No Safe Place: Burma's Army and the Rape of Ethnic Women*, Apple and Martin, (April 2003).

establish crisis centers in existing MCH clinics, conduct advocacy campaigns against violence, include GBV education in schools and refugee camp organizations, and identify sources of legal aid.¹⁴⁰

An IRC representative reports that the protection working groups aim to seek justice for sexual violence against refugees in the camps. According to this representative, Thai law often applies in theory but Thai authorities are reluctant to enforce the law and often refuse to intervene except where Thais are either victims or perpetrators. UNHCR has adopted a policy in all serious cases to put the situation in writing and copy to the MOI at the central level. Local camp administrative systems such as the Karen National Union (KNU) are reportedly problematic because, they are not well documented and the interrelationships of camp committees are unclear. However, KNU and other criminal codes are enforced.¹⁴¹ UNHCR has started its work in three locations. The Karen Refugee Committee (KRC) in Mae Sot has been discussing “governing behavior” to present to the public and media. The KRC has undertaken activities to decrease negative behavior in the camps by decreasing the population’s negative “exposures.” For example, it has closed video shops, stopped card playing and reduced the availability of alcohol. However, the result of these actions is unclear although the local groups are willing to discuss issues and find solutions. In addition, camp committees are reportedly becoming more gender balanced, yet the local groups still require training and capacity building.¹⁴²

Several rape cases have been brought to court with legal assistance provided by the IRC and the Law Society of Thailand. In one case the perpetrator pled guilty and the verdict was pending, while another case was pending in military court. In a third case the police report was done inaccurately, falsely indicating that the survivor was willing to take money to settle the situation. Fortunately, a Thai Law Society lawyer conducted a parallel investigation with a military prosecutor, which, as the IRC lawyer reported, emphasizes the importance of parallel investigations. Women who are raped are referred to the hospital and women are required to report the incident to the police if they want to use the results in court.¹⁴³ While further documentation of GBV directed toward refugees and migrants demonstrates an increased willingness to investigate and discuss the issues, increased GBV programs designed specifically for these refugee populations are not yet common.

ARC has undertaken initial training with the community and groups have formed to address GBV in Nu Poh, Umpiem Mai and Ban Don Yang Camps. A number of local NGOs have undertaken monitoring activities and are trying to work with camp leadership on legal justice, striving for consistency and fairness in cases. Some NGOs have instituted codes of conduct for their staff to abide by but training on the codes is yet to be conducted.

UNHCR initiated GBV activities in refugee camps in recent years. According to the project director of the Community Services Division, UNHCR began its protection initiative by conducting meetings with community leaders with an aim to increase refugee women’s participation in camp committees. The representative also noted that women had to be relieved of other daily duties before they could have time to participate and that women tended to take leadership opportunities through local women’s organizations, although this did not give them opportunities to be involved in camp decision-making. The UNHCR director also conducted workshops with men in the camps to educate them about GBV and to look at their responsibility in GBV.¹⁴⁴

In early 2002, the RHRC Consortium Global GBV Technical Advisor (TA) conducted a four-week visit to the Thai-Burma border; she visited five refugee camps and border towns and met with stakeholders, conducted key informant interviews and provided participatory training workshops on GBV. The GBV TA concluded that GBV prevention and response systems had not been established, although local women’s

140 Committee for the Coordination of Displaced Persons in Thailand (CCSDPT) and UNHCR, Unpublished Report, *Protection Is A Shared Responsibility*, (2002).

141 Meeting with Karn Sermchaiwong, International Rescue Committee, June 24, 2003.

142 Committee for the Coordination of Displaced Persons in Thailand (CCSDPT) meeting, Michael Alexander, Deputy Director, International Rescue Committee, April 9, 2003.

143 Meeting with International Rescue Committee lawyer, Karn Sermchaiwong, June 24, 2003.

144 Trip Notes, meeting with UNHCR representative Steven Vogt, Community Services Sector, UNHCR, February 4, 2003.

organizations had developed some procedures for reporting incidents of violence and assisting survivors. The TA noted the lack of formal support and capacity building of local women's organizations attempting to address GBV in the camps. Communication with UNHCR about GBV incidents was *ad hoc* and legal recourse was limited to the local government camp committees with potential for retraumatization of survivors. The TA recommended establishing a multi-sectoral system for prevention and response that included building the capacity of local women's organizations to take the lead on GBV programming and humanitarian actors increasing their knowledge and awareness of GBV to address gender inequities in camp refugee committees.¹⁴⁵

The RHRC Consortium GBV technical advisor observed that a great deal of monitoring, guidance and nurturing is needed to keep groups on track to ensure that women are not marginalized, local groups do not become vigilantes pursuing perpetrators of violence, and that the groups stay focused on preventing and responding to GBV and do not degenerate into power struggles with camp leadership committees. In addition, education organizations must become involved.

Adolescent reproductive health

IDPs in Burma

According to the BPHWT supervisor there is no information or education available about sexuality and RH for adolescents in the BPHWT-accessible IDP areas of Burma.¹⁴⁶ Adolescents are unlikely to receive RH information or services in Burma unless they are pregnant and can access services, because the focus of the limited RH care available in Burma is on maternal health. In addition, while up to one-third of female respondents in the BPHWT survey stated that unmarried youth should receive education on pregnancy prevention, more than half of respondents reported that they did not know or were silent on the question, possibly indicating disapproval.¹⁴⁷

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

Key factors contributing to the plethora of RH problems among migrants are the limited education and knowledge of youth entering Thailand without their immediate or extended families. Young girls and women are vulnerable to rape and exploitation perpetrated by armed actors and civil authorities. In addition, youth often lack knowledge about sexuality, reproduction and how their bodies function, sexuality and reproduction. Substance abuse, particularly the use of alcohol and methamphetamines, increasingly manufactured in the area, is a problem.¹⁴⁸ Further, traditional leaders have voiced opposition to providing unmarried youth with condoms to prevent the transmission of HIV, and contraceptives. This unfortunate combination of circumstances leads to migrant youths' risky behavior, including unsafe sex, unwanted pregnancies, abandoned infants and unsafe abortions.

A variety of primary and secondary curricula are available for the few Burmese migrant schools. A senior health worker at the Mae Tao Clinic notes that everyone uses their own curriculum for teaching. The UNICEF primary school curriculum for 5- to 12-year-olds includes life skills, hygiene, nutrition and HIV

145 Reproductive Health for Refugees Consortium, *Gender-based violence: Emerging issues in programs serving displaced populations*, Vann, B., September 2002).

146 Meeting with Mahn Mahn, supervisor BPHWT, April 8, 2003.

147 Backpack Health Worker Team, Reproductive Health Survey Preliminary Report, July-December, 2002.

148 Doctors of the World, Field Mission to Thailand-Burma Border concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001, July 2001.

prevention but does not deal with anatomy. The UNICEF curriculum for 13- to 24-year-olds includes youth RH, family planning, STI/HIV counseling, and anatomy and physiology related to family planning.

There are a number of efforts to address the RH of adolescent refugees living in and outside of camps. The Thai Youth AIDS Prevention Project (TYAP) was founded in 1995 to help northern Thai youth to develop their potential as leaders by working to reduce the impact of the AIDS epidemic in their communities.¹⁴⁹ TYAP has seven full-time staff and five part-time staff volunteers and runs five programs for middle school-, high school- and college-aged youth in Thailand's nine upper-northern provinces focused on RH, HIV/AIDS and human rights. TYAP provides training for local groups, supports the formation of youth groups, links with a youth network, carries out training-of-trainers and engages in media advocacy activities. One current project links TYAP to SWAN, KEWG and Chiang Mai Safe House in Tak and Chiang Mai provinces on how to plan and implement RH education programs for 350 adolescents along the Thai-Burma border. An indirect benefit of the project is that Thai youth gain an understanding of the situation of migrants, resulting in increased tolerance for the presence of refugees and migrants in the community.

Refugees in Camps

KEWG is currently developing an adolescent-focused RH curriculum based on CHOICES: a guide for young people (printed by TALC).¹⁵⁰ The curriculum will be translated from English into Karen and Burmese and used in five camps: Mae La, Nu Poh, Umpiem Mai, Tham Hin and Mae Ra Ma Laung.

An ongoing activity of KEWG is to liaise with community leaders to inform and educate them and this is linked with the success of its programs.¹⁵¹ KEWG consulted the Karen Refugee Committee and the camp committee before initiating RH education activities. Initially, the community leaders were resistant to addressing RH issues with adolescents but became more receptive after they learned more about RH issues. Leaders thought of RH as only maternal and child health. A mass campaign on condoms was done in Mae La and Umpiem Mai camps by the student clubs. They also talked to teachers who had become more receptive over time. Condoms are available at KEWG centers in most camps for youth. Seventy condoms per day are taken by youth in Mae La camp.

149 Interview with Amporn Bootan, Executive Director, Thai Youth AIDS Prevention Project, Chiang Mai, June 17, 2003.

150 Interview with Jacqueline, MSF Community Health Coordinator and Secretary of KEWG, Mae Sot, June 16, 2003.

151 Draft Assessment Report Review, Dr Rose McGready, SMRU, October 2005

Reproductive Health Response on the Thai-Burma Border

Chiang Mai and Mae Hong Son Provinces

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

Forced relocation, conflict and gross human rights abuses by the SPDC in Shan state, escalating in the mid-1990s, has forced hundreds of thousands of people from their homes to survive in mandatory relocation settings or to go into hiding in Burma or to cross the border to seek refuge in Thailand. The Thai government does not allow Shan refugees official protection and humanitarian assistance in Thailand. The Shan are considered illegal migrants in Thailand, where they struggle to survive in refugee-like circumstances.¹⁵²

Most of the 150,000 unrecognized Shan refugees living in Thailand, as well as Karen, Karenni and Kachin ethnic Burmese, live in the northern provinces of Chiang Mai and Mae Hong Son which border Shan and Karenni States in Burma.¹⁵³ The majority of Shan refugees are located in the five northern mountainous Chiang Mai border districts of Fang, Mae Aye, Chai Prakarn, Chiang Dao and Wiang Han, where they primarily seek a livelihood in agriculture.¹⁵⁴ Others have moved to Chiang Mai city and border towns, where the economic decline in Thailand has taken its toll by reducing available work in construction and manufacturing. Refugees are working more often out of sight in the service sector, for example, in restaurants and as domestic laborers¹⁵⁵ or working in the night markets. Refugees, particularly women, often only venture from their living quarters to work, for fear of arrest.¹⁵⁶

In June 2001, IRC conducted a needs assessment of three migrant communities residing along the Thai-Burma border. The assessment took place among the migrant communities in Mae Hong Son province, Muang district, Tak province, Mae Sot district and Kanchanaburi province, Sanklaburi district. Key findings from the study showed that those living in small farm communities in Mae Hong Son (and also Mae Sot) had the least access to health and education. Language differences, cost, low education and literacy, poor health knowledge, restrictions on movement and fear of arrest and deportation are major obstacles for migrants' access to health services. The findings also showed that NGOs working with migrant communities lack coordination, tend not to share information with each other and do not provide comprehensive PHC.¹⁵⁷

A 2003 report by the Shan Human Rights Foundation provides data to support the claim that the Shans arriving in northern Thailand should be recognized as genuine refugees rather than economic migrants.¹⁵⁸ The data is based on interviews with 66,868 Shans arriving in Fang District of northern Chiang Mai province between June 1997 and December 2002. The data show that almost all the new arrivals came from 12 townships in central Shan State where the Burmese military have carried out a mass forced relocation program since March 1996 and where the regime's troops have been perpetrating systematic human rights abuses against civilian populations. The evidence demonstrates that refugee flows increased directly after large-scale massacres were committed by the regime's troops, refugee flows are

152 Refugees International, *Refugees International Bulletin*, The Shan in Thailand: A Case of Protection and Assistance Failure, June 22, 2004

153 Doctors of the World, *Field Mission to Thailand-Burma Border Concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001*, July 2001.

154 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

155 Doctors of the World, *Field Mission to Thailand-Burma Border concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001*, July 2001.

156 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

157 International Rescue Committee, *Preliminary Needs Assessment of Migrant Communities Residing Along the Thailand-Burma Border*, June 2001.

158 Shan Human Rights Foundation, *Charting the Exodus from Shan State: Patterns of Shan refugee flow into northern Chiang Mai province of Thailand*, (1997-2002, 2003).

much higher than the annual influx of Shan migrant workers into Fang prior to 1996, there is no seasonal pattern to the inflows as would be expected of agricultural workers, and that people are traveling as families, while in the past migrant workers would typically be adult men between the ages of 20 and 40. The Foundation estimates that 230,000 Shan refugees have arrived in Thailand since 1996. It is thought that Shan are classified as migrants because Thailand does not want UNHCR to have a role and does not want more refugee camps set up. UNICEF and UNHCR have made discreet visits to the region to monitor the situation. In May 2003, there were 1,464 new arrivals. ICRC has interviewed those persecuted in the region and it is thought that SPDC troops tied up villagers during ICRC visits and retaliated against civilians for participating in interviews.¹⁵⁹

The health status of Shan refugees and the psychosocial and legal services for them are difficult to ascertain in part because assistance is primarily supported by a number of local organizations that depend on hardworking migrant volunteers who must operate clandestinely to avoid incidents with authorities that could result in their arrest and deportation and force them to cease their operations. The representatives of these local groups were quite understandably hesitant to schedule meetings at their offices for fear of drawing the attention of the authorities and were equally wary of public meetings.

In the assessment team's meeting with members of these organizations, RH problems such as unsafe abortion, GBV, substance abuse and psychosocial problems, including for adolescents, were identified as the major health issues affecting Shan and other refugees, including for adolescents, in Chiang Mai.

The Women's Commission conducted a site visit to Mompiem village, Fang District and met with the village leader, local doctor and a teacher who reported that the main health problems among the Shan are skin rashes, acute and upper respiratory infections, indigestion and beriberi (a nervous system ailment) caused from thiamine (vitamin B1) deficiency. Those interviewed also said that many youth, as young as 13 years, complain of headaches that the village representatives believe are the result of insecticide exposure from agricultural work. The doctor and two assistants provide PHC to approximately 380 patients per month at Mompiem clinic, located behind the leader's home. Support is provided to the clinic through the Canada Fund. A second Shan doctor and a Thai physician also visit occasionally. Clinic registers showed that 10 to 20 patients visit the clinic per day.

A Women's Commission representative also visited the Thai Mompiem Health Center that, according to its staff, receives 600-700 patients per month, primarily Shan refugees. The staff also reported that the number of visits from Shan patients is increasing daily and that it is difficult to provide consistent care for them due to their mobility. The staff explained that if Shan are legal they pay 30 baht or approximately 75 cents per visit, but if they are illegal, they must pay full price for all of their care.

Safe Motherhood

In its 1998 study, Mahidol University found that the overwhelming majority of Shan migrant women in Chiang Mai delivered at the hospital in spite of the fact that Shan women were accustomed to delivering at home in Burma with their husbands or TBAs. Nearly 75 percent of these migrant women also accessed postnatal care at a hospital or clinic. However, almost 50 percent reported serious or very serious problems during and after delivery.¹⁶⁰

A local doctor at the Mompiem village health clinic in Fang district said that approximately 60 percent of women deliver at home because they have no money for transportation or health care. He estimated that approximately 11 to 12 women have died during their pregnancy or delivery over the last 5 to 6 years. Lack of transportation and insurance coverage were cited as factors contributing to these deaths. The Mompiem clinic does not work with midwives or provide training to TBAs.

¹⁵⁹ CCSDPT meeting, Bangkok, June 2003.

¹⁶⁰ Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*. (Institute for Population and Social Research, Mahidol University, 2000).

In the Mahidol University study, 14 percent of respondents in Chiang Mai with unwanted pregnancies attempted abortions, (72 percent of them were in Burma and 28 percent were in Thailand); nearly half of them reported they were unsuccessful. Sixty percent were attempted by TBAs, 28 percent by health personnel and 8 percent were self induced.¹⁶¹

In the Women's Commission's meeting with an International Planned Parenthood Association (IPPA) representative and a Thai physician in Fang district who attends Shan patients at the district hospital, the women reported that the main health problem for Shan refugees is malaria and that there is also a problem with unwanted pregnancies. The women also stated that Shan women with unwanted pregnancies take a pill called "citotech", prescribed for gastritis, to induce abortion, which is readily available in the local market.

Family Planning

Research among migrants in 1998 showed that awareness about contraceptives in Chiang Mai is high and there is also a significant interest to learn more about specific methods. The overwhelming majority of migrants had heard of oral contraceptives, injectables and condoms, while some 70-80 percent had heard of IUDs, Norplant and sterilization. Even with this high level of awareness, migrants were interested to learn more about the specific methods, particularly oral contraceptives and injectables. In this study, oral contraceptives were the most popular (45 percent) method ever used and the majority (63 percent) of migrants procured them through informal vendors or over the counter in pharmacies, while 35 percent obtained them at a clinic or hospital. Approximately one-third of migrant women had ever used injectable contraceptives, with the majority receiving the injections at a clinic or hospital. Sixteen percent of migrants had ever used condoms, most for the first time in Thailand, and seven percent used sterilization, a more common contraceptive in Burma.¹⁶²

The local doctor at the Mompiem health clinic reported that condoms, pills, injections and IUDs are available and added, "So many women want abortion and we advise them not to do." The village leader commented, "Many young women have too many children when they are not ready and many do not have a father." Support for these young women is provided by the village leader who also said, "People have many children in Myanmar but they should control here." The family planning register indicates there were an average of 100 family planning users per month in the first quarter of 2003, with approximately 50 percent taking contraceptive pills and Depo-Provera. The doctor stated that some women get sterilized after delivery but few men have sterilization because they worry that they won't be able to work.

Contraceptive pills and Depo-Provera are available at the Mompiem health center for approximately US\$0.75 to US\$1.00 for three months. The staff said, "They can ask for condoms, but they rarely do." An IPPA representative and a physician who sees Shan patients at the local Thai hospital were familiar with EC, noting both its efficacy and side effects and added that IPPA provides EC education for Shan refugees.

"Shan men think family planning is only a woman's problem." SWAN staff person

STI/HIV/AIDS

Among respondents in the 1998 Mahidol study, 12 percent reported a problem of discharge, with 86 percent viewing it as at least somewhat serious. Forty-five percent sought care at a drug store, 21 percent visited a traditional healer, 18 percent sought treatment at a health facility and 16 percent sought care from other sources. In addition, 14 percent of respondents experienced difficulty urinating and all

¹⁶¹ Ibid.

¹⁶² Ibid.

respondents sought treatment, with 35 percent seeking care from a traditional healer, 33 percent at a health facility, 28 percent at a drug store and 4 percent reporting accessing other sources of care.¹⁶³

According to research by Mahidol University in 1998, the overwhelming majority of men and women have heard of condoms although this does not mean they have ever seen or used one. In addition, the study showed that condoms are rarely used among married couples, approximately 35 percent of men and two percent of women have ever used condoms and men's use of condoms is often reserved to commercial sex workers (CSWs). The researchers found that migrants, particularly men, often having learned about condoms through AIDS prevention efforts, viewed condoms as a form of protection from infection, although they were aware that condoms may also serve as a contraceptive. According to the study, migrants believe that CSWs have infections and therefore it was necessary to use condoms with CSWs. Ninety-one percent of men in Chiang Mai always used a condom with a CSW, but 95 percent had never used a condom with their spouse.¹⁶⁴

IPPA staff also reported that they did not think HIV was a problem among Shan, but that HIV was a problem among Thai patients who receive care at the hospital. However, IPPA staff said tuberculosis is a problem among the Shan, and the clinic receives medicines from the hospital to provide directly observed therapy for two to three Shan patients per day. In contrast, representatives from SWAN noted HIV as one of the major problems they see in the Shan community, in addition to injecting drug use and trafficking. They note that many husbands are truck drivers and engage in unsafe sex with other women, bringing back STI infections, including HIV, to their wives.

"We are always helping people with HIV." SWAN

Gender-based Violence

From 2000 to 2002, MAP supported a forum to bring women from different ethnic groups together once a month for a meeting and to provide an opportunity to share their experiences of violence. It was during these meetings that women requested training in Thai law. Since that time, MAP has drafted a step-by-step action plan to facilitate psychosocial, medical and legal support for survivors of violence. In addition, MAP established a crisis center with an emergency safe house and support network to assist women who have survived sexual violence and women who are pregnant, because Thai authorities are known to deport pregnant women, and others, in need of emergency shelter. The support network includes volunteers to assist migrants to navigate access to health care. Volunteer activities include accompanying migrants to the local hospital to provide translation and education and to advocate on the patients' behalf. MAP also supports migrant health education via radio broadcast.¹⁶⁵

Moppiem health center staff reported that they do see women who have been raped but they could recall only one specific incident where the women had been raped and became pregnant as a result. She came to the clinic seeking advice and ended up giving the baby to someone else, while the perpetrator paid the woman and was not prosecuted.

"It is difficult to meet with rape survivors because they are in remote locations and women are also fearful to talk about their experience. They don't want to open the can of worms again." SWAN staff member

163 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

164 Ibid.

165 Meeting, Jackie Pollack, Migrant Action Program, March 2003.

Adolescents

IPPA conducts outreach in a mobile clinic to Shan youth ages 13 to 24 years every three months and provides education on contraception and prevention of STIs and HIV/AIDS, as well as the dangers of unsafe abortion. The IPPA peer education program is based on the participation of 15 volunteers and their commitment to train five others and also includes life and communication skills education such as negotiation to not have sex or to use condoms, women's rights and health care.

SWAN noted that Shan youth also face unique pressures. Young people have friends who tell them they must have lots of things which cost money. One girl started in school in grade 9 and lived with two other girls at a Swiss home run by an older woman who taught weaving and gardening projects in Piang Luang. However, other friends told her she should quit her studies to come to Chiang Mai to work as a sex worker, and she got into sex work with her older sister. She became a sex worker and was able to buy a cell phone and wear nice clothes. Young girls see sex work as the only way to make money. SWAN is not able to force young girls to stay in school and girls do have the freedom to leave when they choose.

Additional Findings

During its field assessment to Chiang Mai in 2001, DOW visited a rural health post and health center within a few kilometers of the Burma border where, in collaboration with the MOPH, health education and very basic care were provided to Shan refugees by medics with limited training, officially entitled village health volunteers (VHV), who receive compensation through Thai health insurance. According to DOW: "The medics report seeing a lot of problems that they believe are related to pesticide exposure (such as skin infections, respiratory difficulties and birth defects), in addition to anemia, acute respiratory infection, intestinal parasites, malaria, malnutrition, measles, pelvic inflammatory disease and reproductive and urinary tract infections."¹⁶⁶ Essential primary health care services, including antibiotic treatment and family planning, are not available at these clinics and refugees must access care further inland at secondary or tertiary care facilities such as the Tambon health center in Piang Luang and the Wiang Hang district hospital, where overstretched Tai Yai health workers are able to communicate with Shan refugees. DOW also noted that USAID supported an HIV/AIDS prevention project with condom distribution, in collaboration with a local migrant group called HIV/AIDS Initiative for Mobile and Border Populations (AIMBP), for ethnic minority groups and displaced populations in Wiang Hang district. The project is replicated in five other border provinces: Chiang Rai, Mae Sot, Mae Hong Son, Kanchanaburi and Nakhon Pathom.¹⁶⁷

In its visits to Thai health facilities in Chiang Mai and Chiang Dao, 70 kilometers north of Chiang Mai, DOW found that Thai health care providers are often not originally from the areas where they work, lack local language skills and are challenged to meet the acute care needs of tens of thousands of up to seven different ethnic minority groups from Thailand, in addition to the Shan and other migrants, dispersed in the rural mountainous areas. Although there was an effort to establish an ethnic minority-run health facility in Chiang Dao, in coordination with the MOPH and similar to the Mae Tao Clinic in Mae Sot, it ceased during a period of increased political tensions between Thailand and Burma with regard to Shan refugees. The health care providers do not maintain separate statistics for Shan refugees because the differences between Shan refugees and Thai ethnic Shan are difficult to determine and health providers do not specifically query patients. However, the District Health Officer reported that migrants from Shan

¹⁶⁶ Doctors of the World, Field Mission to Thailand-Burma Border concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001, July 2001.

¹⁶⁷ Ibid.

state in Burma make up approximately 50 percent of health center patients and 20 to 30 percent of patients at its 60-bed hospital. Most migrants do not qualify or cannot afford health insurance or emergency care provided by the MOPH.¹⁶⁸

“Our visits to two district health centers in border areas suggests that there is a wide gap between the Thai providers and their migrant patients, with language and cost being key barriers to care, and district health centers already struggling to serve Thai ethnic minorities” (DOW 2001).

Following its assessment, DOW prioritized reproductive health as the number one need among migrants with the most significant impact on their health and well-being. Specifically DOW reported priority programs should address family planning, STI/HIV/AIDS prevention and treatment, including PMCT, condom distribution, safe motherhood services, violence prevention, safe post-abortion care (PAC) and immunization of pregnant women, infants and children. Strategies for reaching the population include improving outreach and care through mobile clinics and education.

Although local organizations often work in conjunction with the MOPH, which is increasingly more aware of the need to provide preventive care for migrant populations, there is a lack of overall coordination and proactive collaboration by the MOPH to provide comprehensive public health outreach to ensure PHC, including RH, to Shan refugees and other migrants. As in the other major border areas, it appears that refugees and migrants suffer increased RH morbidity and mortality from the lack of preventive care, while the MOPH absorbs the additional more expensive patient costs in its health centers and hospitals.

Mae Hong Son

Ban Kwai and Ban Mai Nai Soi (Site 1) and Ban Mae Surin (Site 2) Camps¹⁶⁹

Ban Kwai, with a population of 18,148¹⁷⁰ mainly Karenni refugees, can be accessed by vehicle within 30 minutes to two hours from Mae Hong Son town depending on whether it is the dry or rainy season. Ban Mai Nai Soi, with a population of 2,879, is along the same road as Ban Kwai but in a less mountainous area and is near a Thai village. Located to the south of the other two camps, Ban Mae Surin is about a two-hour drive from Mae Hong Son in the dry season.¹⁷¹

IRC is the main health provider in these camps. The other organizations working in the camps include Catholic Office for Emergency Relief and Refugees (COERR), which is providing social assistance to vulnerable groups, and the Education Consortium, which works closely with Jesuit Refugee Service (JRS). The local organizations are the Karenni Women’s Organization (KnWO), the Karenni Education Department (KnED), the Karenni Health Department (KnHD), the Karenni Refugee Committee (KnRC) and the Karenni Youth Organization (KnYO).

In terms of access to care in camps, Site 1 (Ban Kwai/Ban Mai) is in proximity of two health clinics and two satellite health centers and Site 2 (Mae Surin) has access to one health clinic and one satellite health center. The referral hospitals are Khunyuam district hospital, which is 1½ to 2 hours from Mae Surin Camp, and Mae Hong Son district hospital, which is a one-hour drive from Ban Kwai/Ban Mai camps.

168 Ibid.

169 Mae Kong Kha (Site 3) was moved to Site 2 in 2002 (BBC, 2002).

170 Burmese Border Consortium, Relief Program Report for the period July to December 2002.

171 Khin, Yuzana, Assessing Adolescent Reproductive Health in the Karenni Refugee Community, Mae Hong Son, Thailand, May 2002.

IRC established reproductive and child health clinics in 1996 in the three Karenni camps in Mae Hong Son province providing safe motherhood; child health, nutrition and growth monitoring; family planning; and STI/HIV/AIDS care. A 2001 IRC final program report provides the following RH indicators: a contraceptive prevalence rate (CPR) of 29.4 percent, no maternal deaths, 96.1 percent of deliveries attended by a trained birth attendant and ANC coverage of pregnant women at 100 percent.¹⁷²

IRC undertook a knowledge, attitudes and practices (KAP) survey in December 1999 in three mainly Karenni camps in Mae Hong Son province among a survey population of 196 men and 308 women between the ages of 15 and 49 representing a total camp population of 16,506.¹⁷³ About a third of respondents had ever attended school, with women more likely to have attended school. Among those who had attended school, 57 percent had primary education and 35 percent had secondary or higher education. Eighty-two percent of respondents were married, with an average of two children, while about one-third had more than five children and about half wanted a total of four children. Respondents were aware of a number of services available at the MCH clinic but less than half knew that family planning services could be obtained there. Sixty-two percent of respondents had received information about HIV/AIDS, most (81 percent) from community health educators (CHEs) and more than 80 percent of people who had heard of HIV/AIDS knew that it could be transmitted sexually, by blood transfusion, from mother to child or through needle sharing. However, a significantly fewer number knew ways to prevent contracting HIV. A little more than half of married respondents were aware of a contraceptive method, 61 percent believed family planning to be useful, only 29 percent of respondents were currently using a family planning method and more than half reported never having used contraception. Recommendations from the survey included: provide literacy classes and income generation activities for the camp population; explore the reasons for the lack of demand for family planning services (cultural or religious constraints or unsure that children will survive); promote family planning methods so women can space their births and maintain their health; involve men in RH activities; and continue to target new camp members for health education.

IRC's 2002 annual health statistics report on the Karenni population residing in Ban Kwai and Ban Tractor (Camp 2), Ban Mai Nai Soi and Ban Mae Surin (camps 3 and 5, respectively) noted a maternal mortality ratio of 130 per 100,000 live births (Thailand 44 and Burma 402) and an overall CPR of 25.3 percent (Thailand 72 and Burma 33).¹⁷⁴ Three-quarters of deliveries were assisted by MCH workers and one-quarter were referred to Thai hospitals.

The KnHD employs health staff in the camp, including support for TBAs and community health workers, through a subgrant from IRC. The RH focal points are the Karenni Reproductive and Community Health (RCH) Supervisor from the KnHD.

Safe Motherhood

The assessment team visited the Karenni camps. At that time, IRC staff did not follow up on referrals to the local hospital. The RH coordinator's past position had been divided among four other staff which made follow-up difficult as it takes a great deal of time. The hospital doctor and nurse come to the clinic once a year to visit with staff. It is not possible for camp clinic staff to visit the hospital because authorities do not grant passes for them to travel to the hospital. IRC provides transportation in the daytime during the week which means emergency transport is a problem on evenings and weekends. 100 percent of deliveries were attended by a trained person. At the time of the assessment visit, there were no maternal deaths. However, some neonatal deaths were reported due to premature labor and the lack of high quality care by clinic staff that require extra support by experts.

The BBC provides bed nets without spray. Malaria incidence was high in May 2003 at the beginning of the rainy season. Pregnant women are tested for malaria every two weeks; however, syphilis testing is

172 International Rescue Committee, April – December 2000; Final Report, Reproductive and Child Health, Mae Hong Son Province. February 2001.

173 International Rescue Committee and the Institute for Population and Social Research at Mahidol University, Knowledge, Attitude and Practices: Health Information Survey in Karenni Camps, (Mae Hong Son, April 2000).

174 International Rescue Committee, Karenni Refugee Camps, Mae Hong Son, Thailand: Annual Health Statistics Report 2002, (March 2003).

not done. Vitamin A is provided to children less than 10 years old and annual eye screenings are performed. Vitamin B1 and a 2,500 mg multi-vitamin are given to pregnant women. The RH coordinator said that staff used a partograph but needed more training on using it properly. She also inquired about obtaining MVA kits and requested training. Both hospitals provide cesarean section and blood transfusion; no blood transfusions are provided in the camp clinics. Anemia cases are referred to the hospital for transfusion. The camp clinic is able to give IV fluids to hold patients overnight until a patient can get to the hospital.

Interviews were also undertaken with local staff at the IRC clinic. KnHD has four supervisors who oversee all activities in Sites 1 and 2; it is difficult for them to supervise Camp 5 due to the long distance. The clinic has a generator for use in emergencies. IRC used to provide petrol but now the KnHD does. When the clinic runs out of petrol, it borrows from other camp partners. Running water is available in the camp. Vaccines are preserved in a gas-powered refrigerator. Chickens move freely in the clinic.

If emergency obstetric cases occur at night, the RCH worker notifies the clinic manager who will call a driver in the local village—20 minutes away in the dry season—to provide transport to the hospital. In the past, sometimes the driver (also an unregistered Karenni) would not be able to enter the camp because the Thai authorities would not let him in past the checkpoint; this meant the patient would be carried by hammock to the checkpoint. Now the driver has a pass that allows him to enter the camp when necessary and radio communication is reliable.

Clients are primarily women for antenatal care and family planning services; only about 10 percent of women's husbands accompany them on their clinic visits. The waiting room is small and becomes easily overcrowded, particularly when antenatal sessions are held. Women receive education during their visits, when the importance of vaccines is discussed. Most women deliver at the clinic; only those who have a rapid labor stay at home. The clinic is in need of MVA and forceps and IRC plans to hire a midwife to train staff on these procedures. A process to ensure sterile instruments was in place; however, a monitoring mechanism was recommended to ensure consistency. There is a laboratory on the same premises. Post-partum hemorrhage is handled in the clinic.

Family Planning

According to IRC's RH coordinator, family planning counseling is done; however, there is some resistance from religious and political leaders as they believe that through its RH program IRC is trying to reduce population growth. Therefore, RH staff talk about contraception in terms of "birth spacing" rather than family planning. Depo-Provera is the most popular contraceptive choice. Many women discontinue use, so the RH coordinator is working to track exit cases in order to discuss with women why they have stopped using a method in order to overcome problems women faced with contraception and/or to confirm that she stopped in order to get pregnant. Very few men are referred for vasectomies. Five women per month are referred to the hospital for tubal ligation, which requires agreement and signature from both husband and wife. At ANC visits, women are queried as to whether they would want to have sterilization if they were referred for an obstetric emergency and their preference is noted in their medical records.

Clinic staff noted that about a quarter of women's husbands come to the clinic for RH appointments with their wives. Staff said they did not see cases of unsafe abortion but agreed it is difficult to distinguish between a miscarriage and induced abortion. They see two to three miscarriages per month in each of the three clinics. On average, about one young unmarried girl comes to this clinic each month. Young unmarried people may come to get condoms but never come for overall family planning services.

According to a 2001 KAP survey conducted in the three camps in Mae Hong Son province, recognition among the population about services available at the MCH clinic had improved significantly from the previous survey.¹⁷⁵ However, more than half of the respondents, particularly men, still were not aware that

175 International Rescue Committee and the Department of Community Medicine, Faculty of Medicine Chiang Mai University, *A Final Report of Knowledge, Attitudes and Practices: Health Information Survey in Karenni Camps, Mae Hong Son*, (Thailand 2001).

family planning services were available at the MCH clinic and half of those who knew about family planning services had never used a contraceptive method. Recommendations included removing barriers to accepting contraception, improving male involvement in the MCH program and continuing health personnel training.

STI/HIV/AIDS

IRC staff use the BBC guidelines to direct treatment of STIs. Common STIs seen are trichomoniasis, candida and gonorrhea. Partner counseling is also done. Condoms are available at the clinic and satellite health center. KnWO also makes them available at their office in the camp and reports to IRC how many condoms have been distributed each month. However, KnYO does not make condoms available at their office. Staff from KnWO do conduct training and awareness raising on HIV. Camp staff also conduct pre-counseling for HIV in the clinic, draw a blood sample and send to the hospital for analysis.

VCT is not available in the camp but the KnHD is interested in establishing this service. Good counseling is not available because staff are not yet trained and knowledgeable on the issue, therefore testing cannot be conducted. KnHD is aware that Mae La camp has VCT and antiretrovirals available because the KEWG has visited the camp and KnHD representatives have visited Mae La camp.

Clinic staff said they did not think people would come for VCT services at the clinic if VCT was offered. At the time of the assessment visit, there were one or two suspected cases of HIV based on individuals' high-risk profile. Three to four people have died in the recent past from AIDS. An HIV-positive woman stayed at the clinic and was attended to by her family there. The staff are beginning to learn how to take care of HIV patients through providing emotional support and healthy food and by treating secondary infections. IRC referred to the hospital a person with advanced AIDS. If a translator is available, counseling can be provided and VCT will be done at the hospital. However, most refugees do not speak Thai or Shan and therefore are not tested.

A study undertaken by the IRC and the Burmese Border Program in 1996 in five camps in Mae Hong Son province investigated the KAP surveys on HIV/AIDS among Karenni refugees.¹⁷⁶ This KAP survey found that of the 344 survey respondents, 66 percent had never heard of HIV or AIDS and only 10 of the 117 people who had heard of AIDS had entirely correct information. The study concluded that newly arrived refugees were much less likely to know about HIV/AIDS; educational materials were needed for illiterate and semi-literate people; and accurate information about HIV/AIDS was needed, especially emphasizing transmission via unprotected sexual intercourse. The study also noted that there appeared to be a zero-to-low prevalence of HIV among the refugee population despite their high-risk location. A 2001 KAP survey conducted in three camps in Mae Hong Son province reported that the refugees had fewer opportunities to access HIV/AIDS health education messages than in a similar survey conducted two years earlier, but the overall knowledge about HIV among those who had received the information had improved.¹⁷⁷

Gender-based Violence

A trainer from MAP in Chiang Mai conducts an annual GBV training for community leaders. Reports of GBV are very few. Often cases are addressed by the community through local groups, such as KnWO and KnRC. Domestic violence is the most common form of GBV.

IRC follows the Burma Border Guidelines (BBGs) on sexual violence but is waiting for the Burmese version. Prior to the 2003 version being published (last version 1999) IRC used the guidelines from the Thai hospital. The rape protocol noted by clinic staff was to provide the survivor EC, refer to the hospital to prevent other STIs and provide emotional support. KWO would also provide emotional support.

176 International Rescue Committee and Burmese Border Program, *Knowledge of HIV/AIDS among Karenni Refugees in Thailand: Results of the 1996 Knowledge, Attitude and Practice Survey*, (February 1997).

177 International Rescue Committee and the Department of Community Medicine, Faculty of Medicine Chiang Mai University, *A Final Report of Knowledge, Attitudes and Practices: Health Information Survey in Karenni Camps, Mae Hong Son, Thailand*, (2001).

Three IRC staff participate in a protection working group. Mae Hong Son agencies, including IRC, Thai authorities, KnWO, UNHCR, Handicap International (HI), World Education Consortium, Shan women's group and Pa-o women's group, meet to coordinate response activities.

Rape survivors are referred to the district hospital to ensure that a legal report can be completed. EC is provided in camp but is provided through existing birth control pills and not in the form of a dedicated EC product. A Karenni refugee was raped in 2002 and referred to the hospital. She did not want to go through the legal process, therefore UNHCR coordinated with IRC, which provided a translator. The process was delayed due to one suspect denying the charges against him.

The 2002 report *If Not Now, When*¹⁷⁸ describes GBV in the Karenni camps. The KnWO estimates that roughly 60 percent of Karenni refugee women have been exposed to GBV. Family quarrels account for the highest percentage of GBV, followed by rape by Burmese military and, lastly, rape by Thai civilians. For domestic violence cases, women's representatives deal directly with the couple, advising the man to not be so hard on the woman. If resolution does not occur, the case is reported to the camp committee. Camp committee members and leaders (male) reported that domestic violence was rare. There are no established medical protocols for intervening in cases of GBV.

Adolescents

A 2001 IRC final program report noted that the main problem encountered by IRC's program was the camp leaders' concern that condom usage would lead to an increased level of sexual activity among unmarried youth.¹⁷⁹ Training of the leaders was undertaken to address this issue.

The assessment team also conducted interviews with the Karenni leadership. The leaders stated that access to condoms was difficult for the community to accept due to religion and culture but noted that cultural traditions were easier to change than religious ones. The KnHD thinks adolescents should have access to condoms and leaders should be brought together to understand the importance of making condoms available to adolescents. Currently, youth get RH information from CHEs and the KWO. CHEs cannot give condoms to adolescents because of a prohibition by community and religious leaders. One leader said, "The greater the population (larger number of people), the more problems with sexuality." Older people and Christian groups were seen as the most difficult groups to convince about the adolescents' need for RH information and supplies. The KnHD planned to have a workshop in October 2003 on RH issues to discuss a new policy; the discussion was to include all health issues as well. They would like to have an adolescent health clinic because they realize that unmarried people are not comfortable attending the regular clinic. There is a youth center run by the KnYO which serves as a place for youth to meet and it has a library with some RH information. However, the leaders recognized that it is not much fun for youth to read about RH and that they need participatory activities to learn more about RH topics. The KnHD director suggested a workshop be held for youth to explain RH issues and to also involve the parents. Staff from KnWO does training and awareness raising on HIV.

IRC wanted to put RH into the curriculum for adolescents but the KnED disagreed with including different pictures of anatomy. Only primary school (ages 7 to 10) has any health and hygiene training, while secondary (age 11 to 13) and high school (age 14 to 16) age youth are ignored. KnHD representatives planned to circulate a report on adolescents' knowledge, attitude and behavior.

Yuzana Khin's study of knowledge, attitudes, beliefs and behaviors of the Karenni refugee population regarding adolescent RH demonstrates a number of barriers to young people accessing RH information and services, including shyness on the part of adolescents, the community perception that RH is only for married couples and the lack of same-sex providers.¹⁸⁰ Girls' lives are more circumscribed than boys in

178 Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing Gender-based Violence in Refugee, Internally Displaced, and Post-conflict Settings*, Ward, J., (2002).

179 International Rescue Committee, April – December 2000; Final Report, Reproductive and Child Health, Mae Hong Son Province, February 2001.

180 Khin, Y., *Assessing Adolescent Reproductive Health in the Karenni Refugee Community, Mae Hong Son, Thailand*, May 2002.

that they often have the responsibility to forage for extra food and wood in the forest and collect water and are afforded fewer opportunities than their male counterparts to move outside of the camp to participate in recreational activities. Education level, marital status and religious affiliations were important determinants of RH knowledge and behaviors. Adolescents who were not in school experienced more pressure to support themselves and their families and tended to marry and have children at an earlier age. Many youth interviewed by Khin complained of a lack of youth-focused activities and looked forward to a plan by IRC to build a youth center in the camp. Khin's study noted that many girls did not have a full understanding of their menstrual cycle and were uncomfortable during the time of their period, particularly if they did not have appropriate sanitary materials. Khin's focus group participants agreed that the adolescent population was sexually active and due to the prohibition against unmarried people accessing condoms, most sexual encounters were unprotected. Khin also found that IRC's MCH clinic data showed that 19 percent of all pregnancies were among adolescent girls and that many emergency obstetric referral cases were young girls.

Girls interviewed noted the family pressure on them to marry at an early age and the inner conflict they felt at wanting to please their parents but not being ready for marriage. Khin's study noted that the schools in the camps punished couples who engaged in pre-marital sex. More educated adolescents had greater knowledge of contraceptive choices and married adolescents, due to religion and the desire for large families, were less interested in family planning options. The unmet need for contraception among unmarried adolescents resulted in unwanted pregnancies and girls seeking clandestine abortion services through traditional methods.

Many youth interviewed by Khin had knowledge of HIV but less about other STIs. HIV was thought to be a problem among men working in town who frequent prostitutes and concern was expressed about young women who use sex to meet their daily survival needs.

Although focus group discussions demonstrated community awareness of GBV, most respondents did not recognize the need for the survivor to receive medical or psychological care. Youth noted that GBV incidents should not be reported to any outside authority such as IRC, UNHCR or the Thai police but should be addressed by the Karenni leadership. They also noted the difficulty women have in proving that they had been a victim of an assault.

Male Involvement

Male involvement is somewhat integrated in IRC information given to clients that attend clinics, e.g., men see posters and ask questions. KnWO CHWs provide education to the whole family, which sometimes involves men. However, there is no special program to ensure integration throughout all IRC programs.

RCH educators are mostly women and medics are mostly men; however, this is slowly changing with a mix of men and women sharing all positions. Male medics have not been able to help women give birth as women are too shy with men caretakers; however, this is also changing and male medics are beginning to help with deliveries. The KnHD leaders said that many people feel too shy to come to the clinic. Thus, some people find one medic they are comfortable with and only go the clinic when the medic is working or seek the medic out at home.

Mae Kong Kha (Site 3) and Mae Ra Ma Luang (Site 4)

(soon to be one site at Mae Ra Ma Luang)

The assessment team did not have time to visit this area but met with the project manager of the NGO Matleser Germany (MHD). MHD took over from Aide Medicale Internationale (AMI) in January 2003,

having had only a small role in the camps prior to this time.¹⁸¹ MHD works in Mae Kong Kha and Mae Ra Ma Luang camps in the Mae Sariang area. From Mae Sariang, it takes one hour by vehicle to reach Mae Kong Kha in the dry season and a half hour more during the rainy season. Depending on road conditions, it takes three to eight hours to reach Mae Ra Ma Luang. These camps will eventually merge into Mae Ra Ma Luang. Each camp has an RH coordinator. The health committee in each camp, which consists of men and women from all sectors including health, education and youth, actively shares information with MHD. The community brings reports to the committee on a variety of issues.

Safe Motherhood

There is a clinical nurse in camp who provides basic EmOC to stabilize patients and each camp has 24-hour emergency transport. SMRU wants to start training midwives. Three to five children died in the past 3 to 6 months which could be due to delivery of babies at home without trained midwives. The KNU promotes the replacement of the population. MHD would like to work with KWO to advocate with them on the need for women to space their children for healthy mothers and children. Screening for syphilis in pregnancy is not done due to the low STI rate. There were only four STI cases in the past year.

Family Planning

There is a concern that local groups providing sarongs, soap and other materials to women who deliver a baby may create an incentive for women to have more children. Another incentive may be supplementary feeding for women; however, MHD observes that babies are healthier now, although there is still a high malnutrition and stunting rate. A BBC study showed that people sell rice and other rations for eggs and vegetables to supplement their diet, therefore justifying the increase in kilocalories distributed to the population. MHD would offer EC in cases other than rape but would need to raise awareness of the availability of EC for family planning as well as in cases of rape.

STI/HIV/AIDS

MHD is also planning to set up VCT services in each camp out of their daily clinic. The health information center indicated that 97 percent of the population wants to get tested, although perception of risk is very low. There were five cases of HIV/AIDS among men and women; all died, most were rejected by family members, and none had access to home-based care or antiretroviral therapy. MHD treats opportunistic infections; currently, there is one person undergoing treatment. MHD is developing a strategy to address HIV/AIDS.

Gender-based Violence

No information was collected on GBV in these sites.

Adolescents

MHD wants to set up a system of peer counselors in both camps. The Karen Youth Organization (KYO) is active in both camps. Adolescents do not have access to condoms; MHD shows a 40 percent increase in teen pregnancies from 2001 to 2002. Males have more partners than females. Religious leaders do not see youth issues (early pregnancy and HIV) as a problem. Some teachers are aware of RH issues and teach the topics to youth but it is not part of the curriculum. Condoms are given to married couples only, not youth. Young people also do not want to come to the clinic to get condoms. There were also some problems that the camp committee did not like the types of novelty (pleasure) condoms being distributed.

¹⁸¹ Information on MHD activities provided by Marie-Theres Benner, Project Manager, Thailand; Senior Regional Advisor, Interview by report authors, Bangkok, Thailand, June 9, 2003.

Tak and Umphang Provinces

Tak province, located in northwest Thailand, shares a 570 kilometer border with Burma and has a population of approximately 150,000 Burmese migrants. Migrants are primarily ethnic Karen from directly across the border where families are continuously uprooted and displaced by the SPDC. Whether fleeing conflict, persecution or economic destitution in Burma, those deemed illegal migrants primarily journey to Tak province, in search of protection and an economic livelihood in seasonal agricultural work or in one of hundreds of factories in the surrounding area.

Life for migrants toiling to eke out a means of survival on US\$1.00 to US\$4.00 a day in the factories and in agricultural settings in Tak province is extremely difficult, and varies only slightly in its hardship, depending on the goodwill of the business owner. Many migrants working in factories are youth who are largely confined to the factory and their crowded living quarters on the premises because they are only allowed one or two days off from work per month, and travel outside the factory, including for health care, puts them at further risk of arrest and deportation.

While health care is available at Thai facilities and through a few local and international NGOs and TBAs, the Mae Tao Clinic is a major provider of health and social services for the migrant population in Tak province. Here, people living in refugee-like circumstances can access a comprehensive array of culturally appropriate free health and social services in their native language by members of their own community.

Other local NGOs supporting RH for people living in refugee-like circumstances, migrant workers and their families include SAW, which supports a safe house for temporary shelter of girls and abandoned infants, mobile clinics to migrant factories and agricultural communities, and an adolescent RH peer outreach project; NHEC/BMA, which support HIV/AIDS awareness and education; and the KWO, which addresses GBV, adolescent RH in the camps and Karen women's social issues in particular.

SMRU also provides antenatal care and safe delivery for pregnancies at risk among migrant populations.

Safe Motherhood

Multi-drug resistant malaria is one of the major causes of morbidity and mortality among migrants living on the outskirts of towns, in agricultural and forested areas and among IDPs in Burma. Malaria is a particular problem for pregnant women and adolescent girls, who also suffer from the related complications of severe anemia, premature labor, spontaneous abortion and low birth weight infants. SMRU provides weekly malarial screening and treatment to prevent maternal mortality in three clinics in Phob Phra district. Screening and early diagnosis of malaria in pregnant women is essential in border villages where malaria prophylaxis is not available due to multi-drug resistant strains.

In addition, research by SMRU in 1989 showed an important association of thiamine or vitamin B1 deficiency, also called beriberi, with infant mortality on the Thai-Burma border where this deficiency is common. SMRU supported the development of protocols and programs to prevent and address vitamin B1 deficiency, including vitamin supplementation for pregnant and lactating women and treatment protocols for beriberi, significantly reducing infant mortality on the border.¹⁸²

Other significant causes of RH morbidity in Tak province reported at the Mae Tao Clinic are complications from abortions. Three hundred and thirty seven women and girls (13 percent of them adolescents) and more than a quarter of them with a history of previous abortion, required hospitalization for PAC, representing 26 percent of the Clinic's RH inpatient caseload in 2003. An additional 15 women were referred to the Mae Sot District hospital for PAC.¹⁸³ While temporary and permanent methods of family planning are offered to women as an integral part of PAC at the Clinic, in at least one official facility in Tak province, temporary methods of family planning are not routinely offered to women as indicated in

¹⁸² SMRU Handouts, Ministry of Public Health, The Meeting of Development of Health Collaboration, Ranong Province, March 27, 2004.

¹⁸³ Mae Tao Clinic, *Mae Tao Clinic Annual Report*, (2003).

standard protocols for PAC.¹⁸⁴ With the annual support of an expatriate midwife volunteer, the Mae Tao Clinic RH project staff has worked diligently to promote family planning at the Clinic and among all of its beneficiary populations through its community outreach and TBA programs, in order to prevent unwanted and mistimed pregnancies.

Comprehensive safe motherhood, including ANC, delivery, postpartum care, basic EmOC, including MVA, and comprehensive EmOC, with the exception of surgical services, are available at the Mae Tao Clinic. Especially complex EmOC patients, including those requiring surgical care, are referred to the Mae Sot Hospital for comprehensive EmOC. Representing 23 percent of its inpatient caseload in 2000, the Mae Sot Hospital has been a steadfast recipient of patients from Burma requiring tertiary care for severe malaria, labor and delivery, emergency obstetric complications, including from septic abortion, acute and severe diarrhea, landmine injuries, tuberculosis (TB) and AIDS.¹⁸⁵ Mae Sot Hospital staff report that patients often arrive at their emergency facilities very late and the hospital's 1999 data reflects 27 percent higher malaria case fatality rates for Burmese. In addition, hospital data indicate that Burmese women were 2.6 percent more likely to have an abortion than Thai women, and Burmese infants were 70 percent more likely to be of lower birth weight than Thai infants. Health workers also routinely make patient referrals from surrounding refugee camps, while some patients arrive independently. International organizations and the Mae Tao Clinic reimburse patient costs; however, others who are uninsured or unable to pay receive in-kind emergency care.¹⁸⁶

According to the Mae Tao Clinic annual report, two-thirds of women delivering at the Clinic in 2003 had received at least two tetanus toxoid injections, while 9.3 percent of women delivering at the Clinic had not received any prenatal care at all, possibly related to travel costs and security constraints, among other issues. Pregnant women at the Mae Tao Clinic are also tested and treated to prevent and manage anemia and malaria and offered VCT for HIV, hepatitis B and syphilis. The rates of these infectious diseases among women have nearly doubled in five years. In 2003, 1.43 percent tested positive for HIV, an increase from 0.8 percent in 1999 (although this is a slight decrease from 1.5 percent in 2002); 2.49 percent of women tested positive for syphilis compared to 1.2 percent in 1999; and 8.52 percent tested positive for hepatitis B compared to 4.5 percent in 1999. The Mae Tao Clinic has undertaken a number of initiatives in recent years to counter these concerning trends, including a hepatitis B vaccine program, expanded and improved VCT, staff training on STI/HIV/AIDS prevention and case management, an improved blood transfusion program and implementation of a prevention of mother to child transmission (PMTCT) program in collaboration with the Mae Sot Hospital where HIV-positive pregnant women are invited to participate in a HIV prevention trial. Women enrolled in the program receive the anti-AIDS drug zidovudine (AZT) prophylaxis from 28 weeks to birth, electively deliver by cesarean section and the infant receives AZT prophylaxis at birth. Women are also provided with milk powder if desired and are followed for one year. However, ongoing AZT for these women is not yet available. The Mae Tao Clinic has also established two new related care and support programs that include home visits to approximately 40 women to provide them with medicines and care, and a monthly support group.¹⁸⁷

In ethnic Burmese migrant communities, TBAs are often either the provider of choice for pregnant women based on their traditional customs and/or lack of education and knowledge, or TBAs are the only health worker accessible to them.¹⁸⁸ In addition to lack of training on clean and safe deliveries, some TBAs are known to undertake unsafe practices, such as uterine manipulation for contraception, and rigorous uterine massage and pummeling and insertion of sticks and other foreign materials in the cervix to induce abortions. These practices were often verified to a member of the assessment team in discussions and focus group meetings with migrant women and representatives of local NGOs. In addition, one very

184 Belton, Suzanne and Maung, Cynthia, *Fertility and abortion: Burmese women's health on the Thai-Burma border*, (Forced Migration Review, Issue 19, January 2004).

185 Doctors of the World, *Field Mission to Thailand-Burma Border concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001*, July 2001.

186 Ibid.

187 Mae Tao Clinic, *Mae Tao Clinic Annual Report 2002*, (March 2003).

188 Sullivan, Tara M., Maung, Cynthia, Naw Sophia, *DRAFT Using Evidence to Improve Reproductive Health Quality along the Thailand-Burma Border*, (February 2003).

elderly TBA reported to an assessment team member that she never referred a woman with complications of delivery anywhere.¹⁸⁹

With an aim to prevent maternal morbidity and mortality, the Mae Tao Clinic, in collaboration with a variety of local and international partners, has trained and supplied over 130 TBAs and more than 30 TBA trainers in the migrant areas of Tak province and the adjacent IDP communities in Burma. TBAs are trained to conduct clean and safe deliveries, educate women about danger signs of pregnancy to promote early referral of obstetric emergencies, collect vital statistics and educate women about maternal and child nutrition, family planning, disease prevention and newborn care.¹⁹⁰

While the number of women who have delivered at the Mae Tao Clinic has increased 57 percent since 2002, only 44 percent of women attending antenatal services deliver at the Clinic,¹⁹¹ which could mean they deliver in a different clinic or it could be a reflection of Burmese women's cultural preference for delivering their babies at home with TBAs as well as travel and security constraints.

In collaboration with the Thai Lawyers Association and along with the work of other organizations on the border, the Mae Tao Clinic has improved its documentation of birth registration and is working to obtain official birth certificates for all newborns. In 2003, 13.4 percent of newborns were low birth weight at the Mae Tao Clinic. Postpartum care includes support of women to breastfeed, administration of ferrous sulfate, folic acid and vitamin A to mothers and growth monitoring, nutritional assessments and supplementary feeding for infants and children.

Family Planning

The significant number of abandoned infants and the high number of women presenting with complications of unsafe abortion at the Mae Tao Clinic and the Mae Sot District Hospital reflect the critical problem of unwanted pregnancy and need for family planning among the migrant population.

The Mae Tao Clinic offers counseling and a range of modern contraceptives in its clinic-based family planning program, in the family planning outreach at five Thai health centers and TBA projects. Adolescent girls represented 17.6 percent of the 6,469 visits made to the Clinic in 2003, a decrease from 22 percent in 2002. The most popular contraceptive method used at the Clinic is Depo-Provera, closely followed by pills, condoms and sterilization, which 203 women and 26 men chose in 2003.

The ratio of births to the number of women admitted for PAC has been tracked at the Mae Tao Clinic by an expatriate midwife who has volunteered at the Clinic annually for over a decade. The expatriate reports that there has been a decline in the ratio of PAC patients to the number of births at the Clinic from a high of 77.8 PAC admissions per 100 deliveries in 1999 to the current rate of 28.8 PAC admission to 100 deliveries in 2003, possibly reflecting the success of the family planning program and the increased use of contraception by the migrant population.¹⁹² SAW also distributes contraceptives that they receive from the Clinic during their mobile clinics to migrant workers and reports that the most commonly used methods are pills and injectables, which are also available on the market and from the Thai Public Health Service.¹⁹³

In a study undertaken by the Mae Tao Clinic of its family planning clients, the majority (85 percent) of respondents were aware of the pill and Depo-Provera but far fewer (40 percent) were aware of IUDs, sterilization and EC. In addition, contraceptive continuation was also low, with only 23 percent of clients using the method for six months or more, reflecting a need to further strengthen client counseling, education and follow-up.¹⁹⁴ SAW staff understand that EC is important for women who survive rape and

189 Field Trip Notes from SAW mobile clinic at a construction site, April 6, 2003.

190 Mae Tao Clinic, *Mae Tao Clinic Annual Report 2003*, (September, 2004).

191 Ibid.

192 Sterk, Inge, email correspondence subject: family planning at the Mae Tao Clinic, February 2004.

193 Meeting with SAW staff, April 6, 2003.

194 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

also for unprotected premarital sex and that it doesn't protect against HIV/AIDS. However, SAW reports that the community is not aware of EC and one representative stated, "Communities faced with hardship do not think of this – infants are abandoned, thrown away, given away and sold."¹⁹⁵ At a site visit to a SAW mobile clinic at a construction worker site, none of approximately 20 women had heard of EC.

"Recently three women came to the Clinic with their young children, from Burma. Two were sisters who desperately wanted a tubal ligation but they could not afford the costs of transportation and payment for security coverage so they cut their beautiful hair short and sold it – its heavy weight brought them a good price in Burma - to pay for a tubal ligation in Thailand."

Adapted from Inge Sterk, volunteer midwife, Mae Tao Clinic

STI/HIV/AIDS

The MOPH reports the prevalence of syphilis among registered migrants was 7.19 percent in 2002 in Tak province.¹⁹⁶ Findings from an RH study undertaken by the Mae Tao Clinic of its clients in 2001 showed that clients were largely unaware of STIs, including HIV/AIDS.¹⁹⁷ The Clinic's director also reports that the oppressive situation and awful working conditions, instability of the migrant community in Thailand and separation from family and social supports lead to increased high-risk behaviors in the community, such as commercial sex work and substance abuse, and condoms are largely unavailable to adolescents and young adults.¹⁹⁸

The Mae Tao Clinic stated that the types of STIs seen at the clinic include vaginal warts, herpes, syphilis, vaginal discharge with itching, dysuria and pain during intercourse. In 2003, 3.8 percent of patients in the RH department OPD were treated for STIs and 4 percent for pelvic inflammatory disease (PID).¹⁹⁹ While Clinic staff follow the BBGs for the management of STIs, health workers reported to a member of this assessment team during a training session that they experience some problems with STI diagnosis and treatment and are challenged by a lack of supplies and appropriate medicines for treatment. Staff also said that senior medics were often not available in the MCH clinic when patients presented with STIs and therefore the expertise available to clients with symptoms was a problem. In addition, health workers report that their patients are shy, ashamed and fearful of confidentiality breakdown and further explain that STIs are often viewed as a women's problem and not a man's problem, affecting partner notification. One solution offered by the health workers was to ensure that senior medics routinely staff the family planning and MCH clinics to ensure better management and treatment of women with STIs. The Clinic has also recently undertaken education and training for its staff on syndromic management of STIs and conducts ongoing education with clients about STIs and other risk factors for HIV.

WV was among the first organizations to undertake community HIV/AIDS awareness raising and education for migrants working in factories and brothels in Tak province. In 2000, an HIV/AIDS KAP survey conducted by Mae Tao Clinic, BMA and the NHEC among factory workers in eight factories in Tak province showed that a high percentage of young women and men had heard of HIV. However, the study

195 Meeting with SAW staff, April 6, 2003.

196 Dr Tares Krassanairawiwong, Chief, Quality & Health service System Development, The Meeting on Development of Health Collaboration Ranong Province, Conference Notes, March 27- 28, 2003.

197 Maung and Sullivan, Draft, *Promoting and Protecting Human Rights Along the Thailand-Burma Border: A Reproductive Health Perspective*, (February 2003).

198 Maung, Dr Cynthia, Challenging Exclusion and Stigmatization: Access for Mobile and Displaced Populations, 15th International AIDS Conference, July 15, 2004.

199 Mae Tao Clinic, *Mae Tao Clinic Annual Report 2003*, (September 2004).

also indicated there were high levels of misconception about the transmission and prevention of HIV, with significant gender disparity in that males consistently scored higher on KAP questions than women, and a low perception of personal risk for HIV among both young women and men.²⁰⁰ The survey findings were used to develop an HIV curriculum for adolescents and to conduct peer education training with condom distribution among factory workers in and around Mae Sot, in agricultural communities and for sex workers. In a report of a study of adolescents' KAP conducted by local organizations on the border in 2001, the authors report that some young women working in factories engage in prostitution with adolescent boys to supplement their meager wages of US\$1.00 per day, putting them at risk of STIs and HIV. They report further that young women are often overlooked in awareness raising and education about the prevention of HIV/AIDS.²⁰¹

Many local and international NGOs such as WV, KWO, SAW, NHEC, BMA, KEWG and others have implemented and coordinated HIV/AIDS community awareness raising and education through peer education and resource materials distribution to migrant factory workers, farmers, sex workers and others in Tak province. Interestingly, one member of this group stated, "Our work has been fruitful for prevention but its weakness is monitoring and evaluation – we educate but cannot recognize if people understand the training."

The assessment team met with field workers from WV, which is also working with the migrant population in Mae Sot.²⁰² WV's HIV activities target three groups: migrants in the community; factory workers; and sex workers. WV staff provide training on HIV in order to motivate trained people to educate factory co-workers, neighbors, friends and others. WV also distributes IEC materials, such as brochures and cartoons. WV continues to meet each month with trained volunteers and continues to provide further training and to check in on their activities. WV also manages two school programs in primary and middle schools. WV goes into schools to do HIV training and gives teacher training in the schools. Collaborating with other NGOs is one of WV's main objectives. For example, their focus is on education and only if they see a sick person would they send the person to Mae Sot hospital for treatment. WV provides pre-counseling to determine if a client wants to be tested for HIV. If they agree, they are referred to the hospital for testing. There is a 30 baht fee for the test if they are registered with a work permit. Those without work permit/insurance pay on a sliding scale. People can access antiretroviral medication at Mae Sot Hospital. In each target site, they also do post-test counseling. There is no home care for HIV-positive persons.

WV-Thailand is supported by the Royal Thai Government which supports their relationship with Thai institutions such as Mae Sot hospital. WV had not faced resistance by leaders who have agreed to distribute condoms to married and unmarried people. However, in the last year religious leaders have resisted condom distribution, but they recently are becoming supportive due to the threat of HIV.

The Mae Tao Clinic's improved and expanded blood transfusion and VCT programs are now available to all clients to support the prevention of HIV among migrants in Tak province. MSF initiated a TB control program in collaboration with the MOPH and others working along the border in 1999 which lends itself to addressing the issue of co-infection of TB and HIV/AIDS. The Mae Tao Clinic referred 571 suspected tuberculosis patients to MSF in 2003 of which 34.1 percent were confirmed positive, an increase from 23 percent in 2002.²⁰³

The assessment team also met with Dr. Cynthia to discuss HIV protocols in the Clinic.²⁰⁴ In terms of HIV testing at the clinic, high-risk groups, for example, sex workers or people having extra-marital relationships, are targeted for testing. VCT is done by request only. All blood donors and pregnant women

200 Mullany, L.C., Maung, C. and Beyrer, C. *HIV/AIDS Knowledge, Attitudes and Practices Among Burmese Migrant Factory Workers in Tak Province, Thailand*, AIDS CARE (2003, Vol. 15, No.1, pp. 63-70).

201 Mae Tao Clinic, Karen Women's Organization and Social Action for Women, *Promotion of Adolescent Reproductive Health for Displaced Burmese Girls in Thailand: Adolescent Reproductive Health Survey, Final Report*, (September 4, 2002).

202 Meeting at World Vision Mae Sot office, Mae Sot, June 16, 2003.

203 Mae Tao Clinic, *Mae Tao Clinic Annual Report 2003*, (September 2004).

204 Meeting with Dr Cynthia Maung, Mae Tao Clinic, June 15, 2003.

are voluntarily tested for HIV and are told to tell others that VCT is available. Those wanting testing must go through the outpatient department or the RH department to get tested. This is beneficial in that people getting HIV testing do not stand out from other patients, but it is not as direct as having a separate VCT center. Sometimes people go straight to the lab thinking this is where VCT is available. From the lab records (April 15 to May 31) five VCTs were performed. Two tests were confirmed positive, one was negative and two who screened positive were lost to follow-up. When a person is confirmed positive, the Clinic treats opportunistic infections. Children receive antibiotic prophylaxis.

The NHEC and the BMA are active in Chiang Mai, Mae Sot and Mae Hong Son. HIV trainings are conducted six times per year, with 20 participants in each session. The participants then return to their areas to do focus group discussion with at least five people. Community workshops are also held three times per year in addition to monitoring visits. The BMA has also hosted health and human rights trainings led by a Burmese doctor now residing in Canada who is also a BMA member. According to Naw Dah Praisangdet, field coordinator for the NHEC and BMA, discussing condoms and their use by married and unmarried adolescents in the HIV seminars is not a problem. She thinks it depends on the attitudes of particular leaders as to whether adolescents are permitted to access condoms. Naw Dah gave a presentation on RH in Mae Pa village, a migrant community, and the audience was receptive and took condoms at the end. However, an NHEC representative was upset that leaders found novelty condoms in a camp and that they were distributing the condoms to youth.²⁰⁵

Gender-based Violence

The Mae Tao Clinic and other local organizations, such as SAW and the KWO, have long noted the GBV suffered by the migrant community, particularly rape and sexual exploitation of women and girls and domestic violence. The Clinic regularly welcomes young girls in need of a safe haven and SAW established an often filled-to-capacity safe house to provide shelter for women survivors of GBV. Young women staying at SAW are supported to attend school, develop job skills, such as sewing, and eventually return to the community.

At one migrant factory worker site the physician supporting a local BMA clinic reported that there were four cases of rape that came to his attention in 2002. Three were reportedly perpetrated by Thai men and one by a Burmese man. The physician said, "After the rape case, we can only do counseling." This physician also reported that domestic violence is a problem and believes the main cause is alcohol and drug abuse.²⁰⁶

In a discussion with women at a migrant worker construction site, women reported that domestic violence was a serious problem. One woman stood up and showed bruises on her body and said that her husband beat her because "she did not clean as she was told." The women also stated that women in these difficult situations often do not seek a divorce because they lack child support.²⁰⁷

Forty percent of adolescent respondents in a study undertaken by local organizations of adolescents in camp and migrant settings in Tak province reported that sexual violence is caused by "natural feelings," clearly highlighting the need for education about GBV.²⁰⁸

205 Meeting with Naw Dah Praisangdet, Field Coordinator for the National Health Education Committee (NHEC) and the Burmese Medical Association (BMA), Mae Tao Clinic, June 15, 2003.

206 Meeting with Dr Khin Seim, migrant factory site, April 8, 2003.

207 Discussion with migrant women during a SAW mobile clinic at a migrant worker construction site, April 6, 2003.

208 Mae Tao Clinic, Karen Women's Organization and Social Action for Women, *Promotion of Adolescent Reproductive Health for Displaced Burmese Girls in Thailand: Adolescent Reproductive Health Survey*, Final Report, September 4, 2002.

In April 2003, a 20-year-old Karen woman was attending the Songkran water festival with her boyfriend when the couple was approached by men riding two motorcycles. The men beat up the boyfriend but then said they had confused the boy with someone else and had made a mistake and offered to take the boy and girl to the hospital. On the way to the hospital, the boy was abandoned and the girl was taken into the jungle and gang raped. Friends were expecting to meet the couple later that night and began looking for them when they didn't show up. The girl was eventually dropped off at a local women's organization's office and brought to the Mae Tao Clinic. At the clinic she received EC, STD prevention medication and tetanus toxoid injection. She said that she wanted to commit suicide if she was HIV-positive. She was provided counseling and stayed one night at the Clinic. Later, the young woman moved to Mae Sot town to join a women's organization while her family continued to live in the refugee camp. Everyone in Mae Sot knew what happened to her, making it difficult for her to live in town. Therefore, the women's group brought her to Chiang Mai to continue her care. The women's group did not report the incident to police—even though they knew that a group of men who roam the streets of Mae Sot were likely suspects—because the women's group members are not legal migrants and were fearful that they would be sent back to Burma. Moreover, they felt identifying the suspects could endanger their own lives if the men decided to take vengeance upon them for reporting.

As told to authors by Dr Cynthia

Although there is a long history of evidence of sexual exploitation and violence against young migrant girls and women in Tak province, a patriarchal culture, as well as migrants' lack of legal status and fear of reprisals from Thai authorities for reporting incidents, are factors that prevent the development of GBV programming. The Clinic has sought and received technical expertise to address GBV over the past several years and hosted training and workshops on gender, discrimination, domestic violence, rape and relevant international human rights instruments for its staff. While there is more awareness, education and documentation, particularly about domestic violence and associated substance abuse, programming to prevent and manage GBV has progressed slowly.

The problem of substance abuse has been undertaken by local NGOs and there is a program on the border that provides assistance to people who have substance abuse addiction entitled Community Addiction Recovery Education (CARE) that is supported in part by the NHEC.

The surgical department at the Mae Tao Clinic tracks statistics of patients surviving physical injuries from domestic violence. In 2002, 23 cases of domestic violence were reported, representing 0.5 percent of patients receiving care in this department, and in 2003 there were 70 reported cases of physical injury, representing 1.2 percent of patients treated in this department. This more than two-fold increase in patients presenting with physical injury related to domestic violence prompted the Clinic to strengthen collaboration between the RH and the surgical department to ensure patients receive counseling and support, as well as education about safe sexual practice and family planning, as appropriate. The Clinic also reports that it plans to develop RH programs involving men that would address domestic violence and alcoholism as one of the associated underlying problems. Although RH staff at the Clinic are knowledgeable about existing protocols for the management of survivors of rape, the Clinic's annual reports do not include statistics for other forms of GBV including rape or counseling.²⁰⁹

WV started work to address the problem of trafficking of women and children in 2001 among Burmese migrants. WV's activities include: 1) prevention of trafficking of those at high risk using a set of criteria to determine true trafficking victims as well as community volunteers who look out for Burmese who are at high risk of being trafficked; 2) rescuing victims of trafficking; and 3) counseling and caring for trafficking victims. WV works with community volunteers to identify trafficking victims and works with the Thai police and Department of Public Welfare. WV does face difficulties with the authorities. All WV staff are

²⁰⁹ Mae Tao Clinic, *Mae Tao Clinic Annual Report 2003*, (September 2004).

registered migrants. In 2003 work permits cost 4,500 baht (approximately US\$113.00), up from 3,500 baht (approximately US\$87.00) in 2002. A work permit provides health insurance which allows holders to pay 30 baht at the hospital for treatment.

It is hoped that the border-wide initiatives of the CCSDPT and the UNHCR-led protection working groups as well as the RHRC Consortium Global GBV TA workshops and her site-specific technical assistance implemented over the past several years in the border area will result in a broader base of guidance and support to local and international NGOs to implement a comprehensive multi-sectoral response to address GBV among migrants.

Adolescents

The number of pregnant teenagers attending antenatal care at the Mae Tao Clinic, as a percentage of total antenatal care clients, increased from 17 to 26 percent from 2000 to 2002.²¹⁰ A survey conducted by local organizations investigating what 10 to 24 year olds know about fertility and family planning was conducted in a refugee camp and factories in 2001 and indicated that knowledge levels were low: just 37 percent could state the age at which women could become pregnant; 52 percent said condom use for unmarried couples was unacceptable; many did not think they could obtain a condom; 43 percent of respondents said they would go to a TBA if they experienced an unplanned pregnancy and 93 percent of the migrant youth did not think they could say “no” to sex.²¹¹ The local groups used the data to develop an adolescent RH curriculum and conduct RH education for 187 adolescents (122 female) through workshops and training of master trainers. In a meeting, representatives of Mae Tao Clinic, KWO and SAW said that their main concern with regard to adolescents was difficulty in accessing this population. They also believed STIs were a growing problem among adolescents because they do not know how to prevent them.²¹²

In 2003, DOW implemented a follow-on project called the Adolescent Reproductive Health Networking Group (ARHNG) to build the capacity of eight Burmese organizations to improve the quantity and quality of sex and RH education and RH services for adolescent Burmese in Thailand and Burma. The project included hosting two training workshops for two participants from each ARHNG organization in addition to training-of-trainers and lessons-learned workshops, as well as study tours to border adolescent RH projects in Chiang Mai and Mahachai. Trainings were conducted in Burmese and project outputs included a training curriculum and handouts that support a standardized adolescent sexual and reproductive health (ASRH) curriculum and workshop reports in Burmese and English. Ongoing ARHNG coordination, fundraising, meetings and networking are conducted by two coordinators, one from the Mae Tao Clinic and the other from KWO, while management and administrative activities are undertaken by a volunteer accountant, treasurer and advisory team.²¹³

In 2003, SAW, a member of the ARHNG, was supported by the Women’s Commission’s Eleanor Bellows Pillsbury Fund to train and support peer educators (PEs). Twenty-one PEs have been trained to provide ongoing ASRH education, contraceptive commodity distribution and medical referral for more than 2,160 young people in six factories in Mae Sot. PEs conduct ASRH group education sessions in the factories where they work. SAW reports that a monitoring and evaluation component was integrated from the start of the project and supports the identification and resolution of the PEs’ training and support needs. For example, PEs were eager for more information about STIs and expressed a lack of confidence in some components of RH, allowing SAW to address these specific needs of the PEs. In addition, an independent evaluation of the project showed that while PEs were overall very satisfied with the support of SAW, they said that males were more knowledgeable about puberty and contraception than females,

210 Sullivan, Tara M., Maung, Cynthia, Naw Sophia, *DRAFT Using Evidence to Improve Reproductive Health Quality along the Thailand-Burma Border*, (February 2003).

211 Mae Tao Clinic, *Karen Women’s Organization and Social Action for Women, Promotion of Adolescent Reproductive Health for Displaced Burmese Girls in Thailand: Adolescent Reproductive Health Survey*, Final Report, (September 4, 2002).

212 Women’s Commission for Refugee Women and Children, Director, Reproductive Health Project, Trip Report, January 2003.

213 Doctors of the World, *Promotion of Adolescent Reproductive Health in Mae Sot*, (DOW Project Report, May 2004).

and that PEs were more knowledgeable about HIV/AIDS prevention than STIs, abortion-related issues and contraception, again providing SAW an opportunity to address these problems.²¹⁴

Thai public health authorities are increasingly collaborating with Thai civil society organizations, international and migrant NGOs to provide PHC, including immunizations in community clinics staffed with Burmese translators and health workers. However, there is still a tremendous unmet need for migrant RH care to be integrated with PHC in Tak province.

WV promotes youth clubs that offer music, drama and sports activities for young people. The assessment team discussed with Dr. Cynthia of the Mae Tao Clinic how best to persuade the Burmese refugee leadership to support comprehensive RH for adolescents and married and unmarried people. Dr. Cynthia highlighted the need to change attitudes and behavior by providing more information about the benefits of RH. Dr. Cynthia believes it is better to continue to provide RH services and not draw a attention to these services. She noted that it is difficult to approach the issue of access to condoms at the policy level because there is no actual policy. She emphasized the importance of educating parents and the leaders. Otherwise, parents will say, "What are you teaching my children?"²¹⁵

Dr. Cynthia suggests targeting school-going children in Burmese/Karen primary (age 5 to 12) and secondary schools (13 to 24). Different curricula are used in migrant schools, some from Burma, others from camp-based programs. The NGO ZOA and the Karen Education Committee oversee curriculum within the camps. ARC has also developed some education materials. Mae Tao Clinic has 14 schoolteachers and 35 children in the school, ages 10 to 14 years. Mae Tao Clinic uses a curriculum developed by the Clinic, KWO and SAW following their adolescent survey project. KEWG is also having the adolescent training curriculum translated. UNICEF and the Ministry of Education in Burma produce teacher training guides and other resources on topics such as life skills, HIV prevention, health and hygiene, and negotiation; but these are not being used in Thailand with Burmese refugees. The Karen Education Department must approve new changes in curriculum. Dr. Cynthia would like to integrate UNICEF materials into the general curriculum.

Additional Findings

The Thai public health department, DOW and Mae Tao Clinic are targeting five Thai health centers that provide antenatal, family planning and vaccines in the Mae Sot area and increasing the number of Burmese-speaking staff. The provincial health officer has agreed to this plan. The purpose is to train Burmese-speaking people from the community to work together with the Thai health centers. International Medical Corps, once registered in Thailand, will be working on migrant health and is interested in doing training of community health workers.

International and local NGOs and provincial hospitals have coordination meetings on health issues.

Mae La Camp

Despite attempts to arrange a visit to Mae La Camp, the assessment team was unable to secure permits to visit the camp during its time on the border. Mae La Camp, with a population of 42,373 refugees²¹⁶ mostly from the Karen ethnic group, is about a 45-minute drive from Mae Sot town in the Tha Son Yang District.²¹⁷

MSF and SMRU are the main health-implementing partners, with PPAT providing specific RH outreach and services. MSF staff includes one doctor, a director of inpatient/outpatient departments, five key medics, 13 regular medics, 35 nurses, 11 lab techs, 30 sanitation workers and 64 home visitors. PPAT

214 Social Action for Women, *Adolescent Reproductive Health Peer Outreach Project*, (SAW Project Report September 2004).

215 Meeting with Dr Cynthia Maung, Mae Tao Clinic, June 15, 2003.

216 Burmese Border Consortium, *Burmese Border Refugee Sites with Population Figures*, May 2003.

217 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T, (October 2002).

provides general RH and STI/HIV prevention information, family planning information and services, Pap smears, breast cancer screening, postpartum care, STI treatment, counseling and medical advice, HIV testing and RH information and services to adolescents through peer education and counseling services.²¹⁸ SMRU is staffed by three physicians and provides antenatal care, delivery, postpartum and newborn care in addition to malaria care for pregnant women.²¹⁹ There is no RH coordinator in the camp.

Safe Motherhood

Syphilis testing is not performed for pregnant women due to extremely low rates in the area. PPAT conducted focus groups in 2000 among 106 respondents, including youth, community and religious leaders, and married and unmarried men and women of Buddhist, Christian and Islamic background.²²⁰ All respondents stated the value of antenatal care and the importance of women delivering at an equipped health center. Different groups noted that it is difficult for some women to walk to the hospital, some women are ashamed to be seen by a doctor, and the cost of services can be an obstacle to accessing services. Due to these barriers, some women continue to deliver at home with the help of neighbors. There was varying knowledge of cancer prevention and treatment among all groups and the cost of services was an issue.

On average, two-thirds of women deliver with trained midwives in Mae La refugee camp and the remaining one-third have delivered with TBAs since SMRU first started working in the camp in 1994. The obstetric facility is very busy with close to 1,000 deliveries per year. The partogram has also been in use since 1994 and midwives were trained in vacuum extraction in 1995. Only cesarean section cannot be performed in the camp and emergency services are available 24 hours per day, seven days per week. In addition, SMRU is planning to implement EmOC training in Mae La camp.²²¹

Family Planning

MSF provided oral contraceptives, Depo Provera and sterilization to camp residents on request as early as the late 1980s and continued these services when SMRU initiated comprehensive RH services as an extension of its antenatal and delivery program. From 1996, any desired contraceptive method was available from SMRU and condoms were encouraged in addition to the other methods for women with high-risk partners. This was a very popular service with more than 200 consultations per month before it was handed over to PPAT in 2000.²²²

In December 1999, prior to initiating its work in Mae La camp, PPAT conducted a baseline RH survey of women, men and youth. There was a clear need for PPAT's planned project given the significant unmet need for family planning education and services revealed in their study. The findings showed that more than 75 percent of respondents agreed to the use of contraceptive methods for family planning. More than half of the men and women reported that they did not want more children and only 23 percent of women were currently using contraception. In addition, nearly one-quarter of respondents did not know about contraceptive methods. Among the respondents who reported knowledge of contraceptive methods, women were most knowledgeable about tubal ligation, vasectomy, injections and pills, respectively,²²³ and men reported more knowledge about condoms, pills, injections and tubal ligation, respectively.²²³

218 Planned Parenthood Association of Thailand, Reproductive Health and Family Planning Services for the Karen Refugees from Myanmar Union in Tak Province, December 1999-2001, December 2001.

219 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T, (October 2002).

220 Planned Parenthood Association of Thailand, Focus Groups on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention among the Refugees in Mae-la camp, Tak Province, January 2000.

221 Draft Assessment Report Review, Dr Rose McGready, SMRU, October 2005.

222 Ibid.

223 Planned Parenthood Association of Thailand, Baseline Survey on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention Among the Refugees in Mae-La Camp, Tak Province, December 1999.

Focus groups conducted by PPAT in 2000 showed that community leaders support family planning activities, while there was varying support for family planning among religious leaders.²²⁴ Men and women not using family planning were less knowledgeable about contraceptive methods than current users of family planning and also had experienced negative side effects and heard rumors that using contraception could prove fatal. Islamic men and women who used contraception did so discreetly because they said it conflicted with their tradition. The respondents indicated they believe that because more children are still wanted, many refugees do not use contraceptives.

A 2002 evaluation of the work of local and international work carried out in Mae La, Umpiem Mai, Nu Poh, Mae Khong Kha and Mae Ra Ma Luang camps raised a concern that refugees may not clearly understand that sterilization is a permanent contraceptive method.²²⁵ According to a PPAT representative at the “Meeting on Health Development Collaboration” in 2004, prior to establishing PPAT’s work in Mae La and Umpiem camps, the CPR was 15 percent. He also said that the problem with EC is that males are carrying the pills around and handing them to girls after sex and not using condoms, so PPAT is very careful about promoting EC.²²⁶ In January 2003, an SMRU representative reported that CPR was 5 percent in Mae La camp and the most recent study by PPAT indicates the CPR is now 25 percent in Mae La camp.²²⁷

PPAT monthly service delivery statistics from December 2002 indicated there were 573 total family planning patients (for injection, pill, condom and one implant); 296 total RH Services patients (vaginal exam, breast check, vaginal discharge, infertility, irregular menstruation, Pap smear, general health) and 177 total counseling services patients for family planning and general RH services. The long-term statistics report from April to December 2002 showed 4,344 new and 12,931 continuing family planning patients; 3,396 new and 11,454 continuing RH services patients; 6,339 new and 3,408 continuing counseling services patients; 158 women referred for tubal ligation; and 117 men referred for vasectomy.

STI/HIV/AIDS

In a PPAT study conducted in December 1999, women and youth had significantly low levels of knowledge about STIs, with more knowledge, albeit limited, about HIV/AIDS. Youth (65 percent) had the most knowledge about preventing HIV/AIDS, followed by men (60 percent) and women (55 percent). The findings indicated that the respondents were most knowledgeable about sexual transmission and there was some incorrect knowledge, among approximately 10 percent of the respondents, such as that HIV could be transmitted through masturbation.²²⁸

The 2000 PPAT focus groups also found that young men were more knowledgeable than young women about STIs; however, all young respondents were aware that using a condom prevents transmission of HIV/AIDS. Many of the focus groups respondents were familiar with HIV/AIDS and had seen people infected with HIV. Some respondents noted that those who “party in town” and do not use condoms may return to the camp infected.²²⁹

Mae La is the only camp along the Thai-Burma border where HIV-positive camp residents have access to anti-retroviral therapy, which is provided by MSF. MSF, SMRU and KEWG collaborate to provide a comprehensive PMCT program including counseling on infant feeding in Mae La. At the time of this report, KEWG was conducting three major projects: PMCT, homecare program for people caring for

224 Planned Parenthood Association of Thailand, Focus Groups on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention among the Refugees in Mae-la camp, Tak Province, January 2000.

225 Karen Refugee Committee, Evaluation of INGO and Karen Organizations in 5 Camps, December 2002.

226 Mr. Montri Pekan, Director Planned Parenthood Association of Thailand, The Meeting on Development of Health Collaboration Ranong Province, presentation and interview notes, March 27, 2004

227 Meeting with Dr Rose McGready, Shoklo Malaria Research Unit, January 2003.

228 Planned Parenthood Association of Thailand, Baseline Survey on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention Among the Refugees in Mae-La Camp, Tak Province, December 1999.

229 Planned Parenthood Association of Thailand, Focus Groups on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention among the Refugees in Mae-la camp, Tak Province, January 2000.

PLWHA and an adolescent RH project. HIV-positive persons also have access to prevention and treatment of opportunistic infections. According to SMRU, problems have been encountered with HIV testing, with nearly 50 percent false positives at the end of May 2002, in part due to use of the rapid tests in a population with a low incidence. Incidence of HIV in pregnancy is estimated at less than 0.5 percent.²³⁰

The KEWG HIV working group was established in 1996 and is supported by SMRU, MSF and various other organizations, including JSI Research and Training Institute, Global Fund for Women and others.²³¹ KEWG representatives talked with the Karen Refugee Committee and the camp committee before initiating RH education activities. Initially, the community leaders were resistant to address RH issues with adolescents but have become more receptive after learning more about RH issues. Initially, Karen leaders perceived RH as limited to maternal and child health. A mass campaign on condoms was done in Mae La and Umpiem Mai camps by the student clubs. KEWG also talked to teachers who had become more receptive to RH issues over time. Condoms are made available at KEWG centers in each camp for youth, with 70 condoms taken by youth on a daily basis. KEWG is responsible for pre- and post-test counseling and works with clients to help them decide whether to undergo testing. When a client does agree to a test, KEWG takes a blood sample and testing is done at Mae Sot hospital. If the test is positive, the client is asked to come back for a follow-up test to confirm. If a second test is positive, the client is referred to the MSF program where the patient is counseled about CD4 count testing and if they agree, a sample is tested at Mae Sot Hospital and then a doctor suggests a treatment plan. KEWG helps clients consider a treatment plan. If the test is negative, follow-up is done at three, six and twelve months to confirm negative status. KEWG provides support to HIV patients and works with a Baptist women's group to provide care for people living with HIV. If someone from outside of camp requests HIV testing and treatment, MSF provides them with information and refers them to other sources in the community, for example, Mae Sot hospital. MSF's community health coordinator stated that there have not been difficulties in the community with people thinking it unfair that refugees in a camp have access to ARV while other refugee and migrant populations do not.

Gender-based Violence

According to MSF, they are using guidelines for medical personnel to respond to GBV and there is community education and awareness as well as improved site design for increased security for women.²³²

KWO refers rape survivors to MSF where they have access to anti-retroviral therapy, counseling, EC, STI prevention and, one month later, an HIV test.²³³ MSF's community health coordinator noted that confidentiality is prioritized and it is the woman's choice as to whether she wants to report the incident to the section leader, camp committee, MOI and UNHCR. In addition, Mae La camp has two safe houses for women opened in 1998 and more scheduled to open in 2002.²³⁴

Adolescents

A PPAT study conducted in December 1999 indicated that 29 percent of youth had no formal education, over half had primary school education and less than 20 percent of young people had pursued education beyond the secondary level. The study also showed that 65 percent of youth were aware of how to prevent HIV/AIDS, particularly with regard to sexual transmission; however, 60 percent of youth did not know about other STIs. A coverage survey undertaken as part of a global evaluation on RH in conflict

230 Draft Assessment Report Review, Dr Rose McGready, SMRU, October 2005.

231 Interview with Jacqueline, community health coordinator, MSF and Secretary of KEWG, Mae Sot, June 16, 2003.

232 Inter-agency Working Group on Reproductive Health in Refugee Situations, Inter-agency Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons, Coverage Survey, Mae La Camp, October 2003.

233 Interview with Jacqueline, Community Health Coordinator, MSF and Secretary of KEWG, Mae Sot, June 16, 2003.

234 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T, (October 2002).

settings states that adolescents do have access to information and education about RH issues and youth-friendly services, but the study does not cover quality of service or level of use by the population.²³⁵

Focus groups conducted by PPAT in 2000 revealed that young people know where to access contraception but need to improve their overall knowledge of family planning. The PPAT 2000 focus groups also provided a variety of ideas for supporting youth activities in the camp. Young people themselves stated that, “They have no definite role.”²³⁶

A 2002 evaluation of the work of local and international work carried out in Mae La, Umpiem Mai, Nu Poh, Mae Khong Kha and Mae Ra Ma Luang camps allowed community leaders to express their opposition to sex education offered to youth and condom distribution to unmarried people.²³⁷

Umpiem Mai Camp

The assessment team visited Umpiem Mai camp. The camp was established in 1999 and is a two-hour drive from Mae Sot district hospital located in rural Phob Prah District about 10 kilometers from the Burma border. The BBC cites the camp population at almost 19,000 as of May 2003.²³⁸ Three-quarters are Karen refugees and the remainder are Burmese refugees.²³⁹ The main health implementing partners are ARC, which focuses on preventive and MCH care, and AMI, which provides curative care including for obstetric complications. ARC has three RCH supervisors and 43 midwives and EPI health workers. AMI has 15 medics who receive 18 months of training at Mae Tao Clinic, including practice and theory; 22 nurses, who have three to six months training; and nine to 10 lab technicians. All staff are Karen and Burmese speaking; one is a Burmese Muslim. PPAT has worked since late 1999 doing outreach and education in the camp on RH issues and RH services, family planning and counseling, mainly for married men and women in the camps. Medical emergencies are sent to Phob Phra District Hospital, while vasectomies and tubal ligations are referred to Mae Ra Maad District Hospital, where PPAT has an agreement with the hospital’s director. According to PPAT, referrals from the camp are rare.²⁴⁰

A 2002 CDC RH assessment found that inadequately spaced multiple pregnancies and GBV were the two main health problems facing Karen and Burmese refugee women of reproductive age in the camp. In addition, the study highlighted a lack of understanding regarding female sterilization—women not realizing the permanent nature of the procedure—and GBV. This study highlights the urgent need to remove barriers to RH care (e.g., improving access to family planning services and prevention and management of GBV) so that women can avail themselves of these life-saving services.

An independent consultant conducted an evaluation of PPAT’s RH projects in Mae La and Umpiem Mai camps, finding that PPAT’s RH services were accessible, efficient and friendly.²⁴¹ In regard to outreach services, PPAT has provided training courses for women, men and youth on a range of RH issues. The consultant found that the project was not ready to be turned over to the camp staff and still required support from PPAT and the Thai-Karen staff. The project has also served Thai residents living near the camp and has initiated a new project to address the needs of the local community as well.

In regard to coordination, PPAT shares reports with ARC but no meetings are currently held to coordinate RH efforts among ARC, AMI and PPAT and to ensure the community is receiving consistent messages

235 Inter-agency Working Group on Reproductive Health in Refugee Situations, Inter-agency Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons, Coverage Survey, Mae La Camp, October 2003.

236 Planned Parenthood Association of Thailand, Focus Groups on Need for Reproductive Health/Family Planning Services and HIV/AIDS Prevention among the Refugees in Mae-la camp, Tak Province, January 2000.

237 Karen Refugee Committee, Evaluation of INGO and Karen Organizations in 5 Camps, December 2002.

238 Burmese Border Consortium, Burmese Border Refugee Sites with Population Figures, May 2003.

239 Centers for Disease Control and Prevention, Division of Reproductive Health and American Refugee Committee, An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand, August 2002.

240 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T., (October 2002).

241 Ibid.

about RH. AMI noted that there is a health committee that meets and includes NGOs and traditional healers, which is helpful to share issues; however, it is not a good venue for coordination.

Safe Motherhood

Forty to fifty deliveries occur each month, shared almost equally among AMI and ARC, and home deliveries, which are usually attended by both a TBA and a midwife. Home deliveries, previously conducted by TBAs, are now often conducted by a TBA with a midwife who will take over if it is not a normal delivery. ARC established this system to ensure optimal home delivery care to women while fostering good working relationships between the TBAs and midwives. In addition, TBAs also work with midwives in the ARC clinic for ongoing training and skill building.

Approximately five women per month are referred from the camp for EmOC either to Mae Sot or Umphang district hospital. ARC handles ANC and deliveries and refers women with obstetric complications to the camp AMI medics who assess and manage their care within the RH clinic (if there are immediate needs) or in their inpatient department. The AMI medic makes the decision to either provide ongoing care in the camp or to refer the women to a Thai hospital. ARC follows up with women on deliveries and wants to increase its attention in this area. AMI noted that when an ARC midwife refers a patient to AMI, she now stays with AMI to see how to address the emergency.²⁴² Also if a woman is referred to Mae Sot, a midwife from ARC will follow up all the way to the hospital to see how the emergency is addressed. AMI noted their frustration that cesarean sections are not done at Umphang hospital, resulting in one case where a woman was referred from the camp to Umphang hospital and then to Mae Sot hospital. Criteria for referrals will be reviewed again in AMI's medics training. AMI doctors go once a week to the referral hospital to follow up with patients and maintain relationships with hospital staff. ARC's RCH coordinator stated that her staff refers cases too often because they lack the confidence to monitor the situation themselves. She thinks it is important that the RCH coordinator be able to stay in camp a few nights a week, when most emergencies occur, to support staff in case of obstetric emergencies until they feel sufficiently confident to handle cases themselves. AMI and ARC are currently working together to revise their referral mechanism to ensure staff are clear about when and where cases should be referred. Referral hospital costs are paid by each agency. AMI noted that maternal problems include high blood pressure, malaria during pregnancy and post-partum bleeding. Emergency transportation is available 24 hours a day, seven days per week.

Results from the 2002 CDC study showed that 89 percent of the women pregnant at the time of the study (8 percent of women interviewed) had received ANC, that about one-third of the women wanted their pregnancy later, and 11 percent did not want the pregnancy at all.

According to AMI, medics are not using forceps or MVA and require training on both techniques.²⁴³ The AMI field doctor noted the need to update her staff's training, for example, on forceps delivery. ARC midwives have recently been trained to use the partograph and are just starting to use it.

AMI's Thailand medical coordinator noted that it is not useful to have equipment in the camp clinic that staff do not know how to use. Medics training is provided for two staff in both Nu Poh and Umpiem Mai camps. SMRU is providing continuous EmOC training-of-trainers for midwives and medics.

The outreach program to surrounding villages has ended but AMI still gets clients from surrounding villages, including Burmese migrants and Thai villagers with and without ID cards. They do not have access to the 30-baht service so they use AMI services.

Services at Umphang hospital cost less than at Mae Sot hospital because Umphang provides a discounted rate for NGOs. Pregnancy and delivery services are free for anyone. AMI is advocating for Umphang hospital to do cesarean sections on a regular basis as there is only one doctor who can perform them but he is not there all the time.

²⁴² Interview with Catherine, AMI Thailand Medical Coordinator, June 16, 2003.

²⁴³ Ibid.

AMI noted that because prevalence is so low, syphilis and HIV testing is only done for blood donors. Typically, families are contacted to identify a blood donor. There are very few transfusions and VCT services are not available. There is a need for counseling and there is demand for testing. AMI would like to work with the MOPH in order to link with the national program and even pay for the treatment.

PPAT's 2000 evaluation noted that according to SMRU the fertility rate has remained stable at 3.1 for each woman (Thailand TFR is 1.93 and Burma TFR is 2.86). PPAT refers clients to Mae Ra Maad District Hospital for vasectomies, tubal ligations and other invasive procedures, where the director provides services to clients who are more satisfied than with the previous referral site. The consultant recommends that Umpiem Mai obtain an in-camp physician through increasing compensation or contracting with MSF for a foreign physician and increasing the skills of the head nurse so that she becomes more independent.

Sometimes, the relationship between trained midwives and community TBAs poses problems. The TBAs are often powerful community leaders whom the midwives are not able to challenge. For example, ARC's RCH coordinator told of one situation where a TBA would not let a midwife manage an obstetric emergency and the woman ended up being referred to the hospital too late. The damage suffered caused her to have a hysterectomy after having only her first child.

Family Planning

According to a 2002 survey by the CDC of women of reproductive age in Umpiem Camp, knowledge of any family planning method is high, at 100 percent. Seventy-eight percent of women had used a family planning method at some time in their life and 43 percent of women were using contraception at the time of the survey, with more than half of these women choosing Depo-Provera.²⁴⁴ Oral pills and condoms are the next most common methods of birth control. Of the 43 percent using contraception, 45 percent wanted to space births and 53 percent did not want any more children. At the ARC clinic, family planning counseling is offered certain days of the week but staff stated that a woman would not be turned away if she came on a day that family planning counseling was not offered. According to PPAT, the primary age of their contraception clients is 25 to 44 years, with a total of 274 users from this age group in April 2003. The number of clients decline by age, with 48 users among the 20 to 24 year age group and 32 users among the 10 to 19 year age group. AMI notes that a woman would have access to sterilization only if she had been referred to the district hospital and had a difficult delivery that prevented her from having future safe pregnancies. However, ARC offers sterilization to both males and females when couples have received appropriate information and counseling and desire a permanent method of contraception. The referral is not restricted to women who have had a difficult delivery preventing her from having future safe pregnancies. This discrepancy might reflect the clinical focus of AMI and the community focus of ARC.

PPAT's December 2002 Monthly Service Delivery Statistics showed: 218 total family planning clients (for injection, pill, condoms and one implant); 226 total RH services patients (vaginal exam, breast check, vaginal discharge, irregular menstruation, general health); 206 total counseling services patients (for the same topics as in RH services, above). PPAT's Quarterly Services Statistic Report from September to December 2002 indicate 1,470 new and 3,606 continuing family planning patients; 1,869 new and 7,488 continuing RH services clients; and 4,417 new and 1,685 continuing counseling services patients. This same report noted that five women were referred for tubal ligation and six men were referred for vasectomies.

PPAT's independent consultant noted that men participating in PPAT's RH trainings realized the importance of birth spacing but continued to desire large families, and most would not accompany their wives to the PPAT clinics, demonstrating the need to target younger men who showed particular interest in gaining further information on topics such as HIV/AIDS.

244 Centers for Disease Control and Prevention, Division of Reproductive Health and American Refugee Committee, An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand, August 2002.

STI/HIV/AIDS

The 2002 CDC study showed high knowledge of any type of STI, including HIV/AIDS, at 99 percent. A high level of knowledge was also demonstrated in regard to HIV/AIDS transmission and prevention. Interestingly, 61 percent of women surveyed stated their intention to get an HIV/AIDS test.

AMI uses a syndromic management approach for STIs. Syphilis testing for pregnant women is not done due to extremely low rates. Aside from HIV, Hepatitis B and Syphilis testing for blood transfusions or donations, AMI does not do any laboratory testing for STIs. Although HIV testing is not done, sometimes people come to donate blood and know if they are rejected that they may have HIV. If a woman is known to be HIV-positive through care she received during a previous pregnancy, she would be referred to the Mae Tao Clinic where treatment is available to PMTCT. It is possible to be tested for HIV at Thai hospitals but it is suspected that no pre- or post-test counseling is offered. In the camp, patients do have access to prevention and treatment of opportunistic infections and married couples have access to condoms. However, there is no counseling for HIV-positive pregnant women on infant feeding, no access to PMTCT and no anti-retroviral therapy for HIV-positive persons. Universal precautions are adhered to.

The KEWG coordinates an HIV prevention group. PPAT is doing Pap tests for women, with positive cases being referred to AMI. AMI is frustrated by this situation because it cannot treat a woman for cancer due to lack of funds associated with treatment at referral hospitals. AMI considers Pap testing without viable treatment options a waste of scarce resources. PPAT's evaluation noted that there were no cases of STIs treated in the camp, demonstrating the need to increase STI prevention, diagnosis and treatment services.²⁴⁵

PPAT's independent consultant found the main project constraints to be the need for an on-site physician and more attention to preventing, diagnosing and treating STIs, including continued staff training.

In 1999, the Karen Refugee Camps Women's Development Group (KRWDG) was formed, based in Mae Sot, which works to assist women's representatives in the camps and to respond to the needs of Karen women.

Another 2002 CDC RH assessment, conducted in collaboration with MHD, ARC and MSF in Mae Kong Kha, Umpiem Mai and Mae La camps, noted a family planning prevalence rate of 45 percent, a high knowledge of HIV among the population and a 20 percent prevalence rate of domestic violence in the community.²⁴⁶ The study findings allowed the health staff to plan to identify women who could be at risk of frequent pregnancy; develop ideas for further outreach to the community on HIV/AIDS education and possibly train counselors to perform comprehensive HIV testing; and use the data to confirm violence as a community problem that needs to be addressed through prevention activities focusing on domestic violence.

Gender-based Violence

ARC does not use any set protocols to manage GBV cases though both ARC and AMI referred to the BBG guidelines. Aside from a half-day meeting with NGOs, including an overview and introduction to GBV by the RHRC Consortium GBV TA, no training of staff or awareness-raising in the community on GBV has been done. EC for rape survivors is available through ARC but the community lacks awareness of its availability. A survivor also could be referred to Mae Sot hospital for insertion of an IUD and to Mae Tao clinic for post-exposure prophylaxis.

The KWO and camp committee are often involved in addressing a situation involving GBV. It has been heard anecdotally that a situation may be resolved with a rape survivor being forcibly married to her

245 Planned Parenthood Association of Thailand, *An Evaluation of the Project: Reproductive Health Services and Family Planning for Refugees from the Myanmar Union in Northwestern Thailand*, Violante, T., (October 2002).

246 Centers for Disease Control and Prevention, Division of Reproductive Health, Malteser Germany, American Refugee Committee and Médecins Sans Frontières, *An Assessment of Reproductive Health Issues Among Karen and Burmese Refugees Living in Thailand*, August 2002.

violator. In one case (AMI noted) a 14-year-old Muslim girl was raped. The KWO wanted to marry her to the perpetrator but AMI, ARC and UNHCR stepped in to prevent this from occurring.

According to the 2002 CDC survey, 56 percent of women reported at least one incident of domestic violence, and a quarter of the women reported at least one incident of violence by other perpetrators.²⁴⁷ The military were the most frequent perpetrators of physical violence (42 percent), and verbal abuse was mostly carried out by a family member other than the husband (21 percent). The majority of women reporting domestic violence or violence by another perpetrator preferred to share this information with a friend or family member and rarely reported violence to the medical staff.

According to the RHRC's publication *If Not Now, When?*, the leader of Umpiem Camp denied any knowledge of violence against women, but suggested training in GBV might be worthwhile.²⁴⁸

PPAT's independent consultant recommended that GBV be added to training courses as key informants noted cases of rape of Karen women by Burmese soldiers or by intimate partners. The PPAT consultant also recommended that GBV be added to training curricula and addressed more openly in the camp to show support for survivors and to aid prevention activities.

Adolescents

The Women's Commission visit to Umpiem Mai camp revealed a dearth of attention to or services for youth. Girls do not have access to sanitary napkins which forces many to stay home from school. Young people are not comfortable going to the clinic which is filled with mothers attending to pre- and post-natal care and do not want to go to the clinics to request condoms for fear of seeing an elder they know. Youth may not be given condoms anyway because the community perception is that only married couples should have access to condoms. PPAT says that youth come to their clinics for education and supplies but must get education before getting condoms and, in any case, only married couples could obtain them.

A focus group conducted with 12 boys and seven girls ages 12 to 20 demonstrated interest in RH issues but a lack of complete understanding. Young people knew about HIV but did not have all the facts about transmission or prevention. Youth said condoms were available at the KEWG center but comments suggested that only married youth should access them. Also, there was distrust among some boys in the group as to the efficacy of condoms regarding proper use, expiration dates and continued use. The young people stated that problems for youth included wanting to try everything; drugs, including alcohol, opium, amphetamines and marijuana; early marriage and divorce; and gossip. Finally, a discussion about violence centered around women who have sex with Thai soldiers to earn money for survival, but they also had heard of women being raped in the camp. When asked about rape survivors being married off to their perpetrators, girls said many girls would run away or commit suicide.

According to a survey conducted by Mae Tao Clinic, KWO and SAW among youth in Umpiem Mai camp, 40 percent of respondents could get a condom but half said condoms should not be used by unmarried couples.²⁴⁹ Most youth surveyed knew about HIV (90 percent) but knew little about other STIs. Youth also had a high level of knowledge about forms of birth control such as the pill, condom and Depo-Provera. Sixty-nine percent stated that both men and women are responsible for preventing a pregnancy. In the event of an unplanned pregnancy, 43 percent said they would go to a TBA and a third to the clinic to induce abortion or get advice; almost a quarter stated they would continue the pregnancy.

The PPAT consultant stated that it was still essential to increase understanding among the Karen of the importance of providing education to adolescents about RH and to dispel the myth that providing them with condoms would lead to promiscuity among youth.

247 Ibid.

248 Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing gender-based violence in refugee, internally displaced, and post-conflict settings*, Jeanne Ward, (April 2002).

249 Mae Tao Clinic and Karen Women's Organization, *Promotion of Adolescent Reproductive Health for Displaced Burmese Girls in Thailand: Adolescent Reproductive Health Survey*, Final Report, (September 4, 2002).

Additional Findings

An evaluation conducted in December 2002 to assess the services, including health, provided by INGOs and Karen organizations in five Karen camps provided important feedback from the refugee community.²⁵⁰ The findings showed appreciation for NGOs that have made an effort to involve and inform the community in their work and allowed community leaders to express their opposition to sex education offered to youth and condom distribution to unmarried people. The survey also raised a concern that refugees may not clearly understand that sterilization is a permanent contraceptive method. The study highlighted the need to continue education and advocacy efforts with community leaders in order to advance RH information and services. Videos on family planning and sex education were not seen as suitable for children.

Nu Poh Camp

In February 1997, in collaboration with AMI and KRC, ARC responded to a mass movement of refugees from northern camps in Thailand fleeing from advances by the Burmese army. Approximately 5,000 Karen stopped in a roadside area 5 kilometers from the Burma border called Keh He Pah Leh and were later settled in Nu Poh camp, located approximately 10 kilometers from the Burma border. Populations fleeing from other northern camps and an increasing influx of displaced people from Burma brought the total camp population to a stable level of approximately 10,000 Karen refugees in 1997. All components of the MISP were implemented to some degree at Nu Poh camp; however, although condoms were made available, they were not accessed due to cultural constraints: condom use in the Karen community is believed to promote promiscuity among unmarried people. In addition, comprehensive RH services were planned, safe delivery and referral systems were established, health staff were trained on safe delivery, family planning, STIs and a surveillance and monitoring system was developed.²⁵¹

Currently, Nu Poh camp has approximately 12,345 residents and there were 300 new arrivals in May 2003. The assessment visit to the camp included a half-day site visit to ARC programs and structured meetings with adolescent girls and community leaders. Logistics and time constraints did not allow a visit to clinical programs provided by AMI in the camp; however, meetings were held with a new AMI physician and AMI's country director. The RH program director also held two meetings with staff at the 10-bed Umphang Hospital.

Safe Motherhood

ARC local health workers including, two RCH supervisors and 22 midwives and expanded programme on immunization workers, provide antenatal care in a large clean structure built of bamboo with separate rooms to allow privacy for consultation and counseling. The health workers provide RH education for women in the antenatal clinic waiting area, which had more than 30 women on the day of the visit and was filled with brightly colored pictorial health education posters.²⁵²

The crude birth rate is 31.4 per 1,000 population and 100 percent of deliveries are attended by skilled personnel.²⁵³ The ARC RCH coordinator said there were two maternal deaths in March, one a new arrival who died of meningitis and the other a 26 year-old woman who seemed to suffer from mental health problems and refused medical care. There were no maternal deaths and five neonatal deaths with a neonatal mortality rate of 14/1,000 live births from June 2003 through May 2004. The low birth weight rate over the same time period was 12.7 percent, with an average birth weight of 2.86kg (6.3lb).²⁵⁴

250 Karen Refugee Committee, Evaluation of INGO and Karen Organizations in 5 Camps, December 2002.

251 American Refugee Committee, *Thailand/Burma Border RH Project Report*, (April 1997).

252 American Refugee Committee, document of reproductive health information and statistics, October 2004.

253 Ibid.

254 Ibid.

In a meeting with camp refugee section leaders and representatives of camp health education and camp committees, representatives stated they felt that safe motherhood services were “quite good at the camp” but that too many young girls become pregnant. The leaders said that about four to five adolescent girls become pregnant every month, and that in the previous month, 15 of the pregnant girls were under 18 years old.

Umphang hospital staff reported a concern that emergency referrals from the camps often come too late to the hospital and that they believe there are times when referrals are not made when they should have been. They also cited problems with referral documentation. According to its director, the Umphang hospital provides delivery and EmOC services to patients free of charge because, as the hospital director stated, “MCH is particularly important because it is a basic of life.” The director said that he prefers MCH patients to be transferred from Nu Poh camp to the Umphang hospital because, among other things, he is concerned about the lack of a stable power source in the camps. The director also said that it would be good if health workers were trained to use portable ultrasound machines in the camp for early detection of complications. The hospital nurse also reported that there was a need for camp health workers to improve referral documentation to facilitate better emergency care at the hospital. AMI staff reported that they were working to improve the basic EmOC skills of their health workers so that patients are stabilized before transfer.

A safe house has been established in Umphang where high-risk maternity patients from the camps can stay before delivery so they are closer to the hospital at the time of delivery. The hospital director requested a surgical kit that was later provided through the RHRC Consortium’s Averting Maternal Death and Disability project. The hospital nurse requested and received a Steps of Delivery poster from the Mae Tao Clinic.

Family Planning

ARC staff reported that family planning was a priority for them and that all modern methods of contraception were available. PPAT of Thailand established four health outposts in Nu Poh camp. ARC also provides education and condom distribution through RCH educators to men and women on birth spacing, including natural methods to support family planning decisions. In May 2004, the contraceptive coverage rate was 27 percent in Nu Poh camp, with Depo-Provera the preferred method (12 percent), followed by tubal ligation (9 percent), oral contraceptives (3 percent), vasectomy (2 percent) and condoms (1 percent). ARC provides funding for refugees to access tubal ligations and vasectomies at the Umphang hospital following appropriate counseling. EC is available for survivors of rape in the camp.²⁵⁵

Umphang hospital was preparing to undertake a new community outreach program to 10 Karen villages surrounding Nu Poh camp and requested family planning supplies, including condoms and Norplant. The supplies were later secured from PPAT.

HIV/AIDS

The ARC RCH coordinator reported that widespread distribution of condoms was stopped because the camp committee objected. Condoms are now only distributed by the ARC community RH and child health staff. ARC recently engaged an HIV/AIDS technical advisor to strengthen and expand HIV/AIDS programming.

Gender-based Violence

According to the ARC RCH coordinator there have been two alleged cases of rape in the camps, both of mentally disabled women. Both incidents occurred in 2001 and their situations were discovered when the young women became pregnant. The women are now closely followed and supported by the KWO, which is committed to working on GBV in Nu Poh camp.

²⁵⁵ Ibid.

According to camp section leaders, a camp GBV committee was established in 2002 and consists of 15 members that meet once a month. Currently, domestic violence incidents are reported to the GBV committee, which attempts to intervene to counsel the couple. If the situation does not improve the committee will recommend a separation. If a woman is raped she is referred to the Thai hospital for care. Umphang hospital staff follow a standard protocol for rape survivors and a copy of the WHO protocol was provided to them for reference and comparison.

ARC Umphang has received technical assistance and support from the RHRC Consortium Global GBV TA and also participates in a protection working group meeting every two months in Mae Sot to discuss GBV issues and programming.

Adolescents

ARC health staff reported that sanitary materials are not available to young girls and women in the camps, which prevents them from attending school. Although UNHCR planned to provide sanitary supplies, it experienced a funding problem and did not start the project.

In a meeting with 25 adolescent girls in Nu Poh camp they reported that they do not currently receive information about RH in school. They also said that most girls marry when they are 15 to 16 years old. Among the participants in this meeting, most hoped to have two or three children although a few said they wanted four, and one said she wanted five children. They also said they would obtain family planning supplies and condoms at the ARC RCH clinic. Participants said that they knew about a few cases of rape in the camp but 15 of them knew about girls and women who were raped in Burma.

A youth subcommittee comprising seven members (five boys, two girls) was established to impart information about health, community awareness, tradition and culture, physical education and drug use and abuse. The community is seeking funding to support its youth activities. It is also involved in developing a youth curriculum with representative input from the camp's women's organizations, youth, religious groups, ARC, AMI, school headmaster, the camp education committee and the camp committee itself.

The 2002 report *If Not Now, When?*²⁵⁶ notes that women's representatives respond to five or six reports of domestic violence each month.

Samutsakorn Province

There are approximately 143,000 Buman, Mon, Karen, Rakhine Pa-O and Shan migrants, of whom only about 14 percent are registered, in the central province of Samutsakorn.²⁵⁷ It is a fluctuating population based on the state of the economy and the amount and timing of Thai immigration enforcement, particularly in the seafaring industrial center of Mahachai. Here, often with the accompaniment of agents they become indebted to for transport and facilitating employment opportunities, migrants find work in the shrimp processing center (Talud King) or pass through it to seek work in the fishing industry in other areas of Thailand.²⁵⁸

In Talud King, approximately 3,000 (down from 10,000 preceding mass immigration crackdowns in July 2000) migrants live in overcrowded concrete housing facilities or dilapidated shacks in fear, particularly women, of arrest, deportation and violence and, therefore, rarely venture out. CARE International,

²⁵⁶ Reproductive Health for Refugees Consortium, *If Not Now, When? Addressing gender-based violence in refugee, internally displaced, and post-conflict settings*, Ward, J., (2002).

²⁵⁷ Doctors of the World, Field Mission to Thailand-Burma Border Concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001, July 2001.

²⁵⁸ Ibid.

through the Raks Thai Foundation, established a base in Mahachai in July 1999 and supports basic health care services, provided by Thai and Burmese doctors and nurses through a static clinic and weekly mobile services from a van in a market just outside of Talud King. Their work is complemented with an outreach program utilizing Thai and Burmese volunteer peer educators with a peer supervisor system. This program is challenged by volunteer turnover, primarily due to the mobility of the community. The Ministry of Public Health also recently established basic clinic services for migrants outside Talud King. While the two programs provide similar services, in the same area, for the same population, there is only ad hoc collaboration between them. Unfortunately, according to DOW, neither clinic services are well used by the migrants, primarily because of security and financial barriers. The main health problems among clients seen at the clinic are occupational injuries, skin infections, MCH problems, violence and infectious diseases, while little information was available on HIV.²⁵⁹

Research conducted by the CARE Thailand/Raks Thai Foundation in 1998 showed that most migrants seek health care in a stepladder approach, beginning with traditional practitioners, friends and local pharmacies. If they do not achieve adequate results, they will progress up the ladder to private clinics and hospitals with government-run facilities a last option due to language barriers, costs and fear of arrest.²⁶⁰

Safe Motherhood

The majority of migrant women interviewed by Mahidol University researchers in 1998 reported that they do not access Thai health care providers for safe motherhood services and rely on traditional sources of care. In addition, the overwhelming majority of women reported complications from pregnancy and childbirth as serious problems. The researchers also recommend further study based on the many stories they heard about infant deaths in focus group discussions and in-depth interviews.²⁶¹

Family Planning

In-depth interviews conducted by Mahidol University in 1998 reveal that women seek abortions for unwanted pregnancies when they are desperate, for example, from fear of losing their jobs. Informal health providers reported that many women suffer from complications of abortion and require emergency care.²⁶²

STI/HIV/AIDS

Qualitative information obtained from focus group discussions and in-depth interviews conducted by Mahidol researchers in 1998 indicate that some people have extremely limited knowledge about STIs and seek traditional remedies for care. In addition, researchers learned that Burmese attitudes were reflected in a cultural division of good and bad girls, with CSWs clearly viewed as bad girls who have HIV infections, and therefore men should use condoms with them.²⁶³

A study conducted by CARE Thailand/Raks Thai Foundation in 1998 among migrants showed that the majority of respondents were aware that gonorrhea, syphilis and HIV/AIDS were STIs. Further, many understood the major modes of HIV transmission, but there were also significant misconceptions about how HIV is transmitted, such as by sharing clothing and from mosquito bites and toilets. Research findings also indicate risky behaviors among the respondents, such as sex with more than one partner in the previous three months (20 percent of respondents), sex with commercial sex workers and little use of condoms among married couples. Only 11 to 17 percent of respondents in the study believed they could get HIV from their spouses or partners. In addition, less than one-third of respondents reported ever using

259 Ibid.

260 CARE Thailand/Raks Thai Foundation, Migrant Workers and HIV/AIDS Vulnerability Study Thailand, September 1999.

261 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

262 Ibid.

263 Ibid.

condoms and most said this was because condoms diminished feeling, while others said they were unable to obtain condoms.²⁶⁴

Gender-based Violence and Adolescents

No information was obtained.

²⁶⁴ CARE Thailand/Raks Thai Foundation, Migrant Workers and HIV/AIDS Vulnerability Study Thailand, September 1999.

Kanchanaburi Province

Migrants

Kanchanaburi is the third largest province in Thailand and shares a 347 km (215 mile) border with Burma across its Tanintharyi division and Mon and Karen States. There were approximately 100,000 undocumented migrants within its borders in 1999 and the number of migrant workers officially registered in 1998 was 9,581. Kanchanaburi comprises three administrative districts— Sangkhlaburi, Saiyoke and Thong Pha Phum.²⁶⁵ As the Women's Commission's assessment team did not visit the migrant population in this province, the focus of the summary here is based on a study undertaken by the Asian Research Center for Migration at the Institute of Asian Studies in Chulalongkorn University from January 1998 through March 1999 and published in March 2000 on cross-border migration and the HIV/AIDS situation among approximately 20,000 migrants in the Sangkhlaburi District of Kanchanaburi Province.²⁶⁶

At the time of the Asian Research Center for Migration research, the migrant population of 20,000, consisting primarily of Mon (43 percent), Karen (36 percent) and Burmese (16 percent), was nearly twice the size of the local Thai population. The researchers report that migrants in this community have close cultural similarity with the local Thai population and speculate that the favorable attitude of Thais has engendered their integration within the community and their lack of interest in returning to Burma. Although official registration was limited to approximately 50 percent of the migrants in Sangkhlaburi district, 88 percent of migrants reported accessing government or private health facilities.

STI/HIV/AIDS

A knowledge, attitude and practice survey of 327 respondents in Sangkhlaburi district showed that knowledge about HIV/AIDS is low, particularly among people with the lowest incomes, and that widespread misperceptions about HIV/AIDS fuels stigmatization of PLWHA. The researchers also reported that while commercial sex work is not common in this district, it does occur among indirect sex workers with Thai uniformed men and officials, traders, truckers, wealthy residents and, rarely, migrants. In addition, the researchers found that more than one-fifth (22 percent) of migrants participate in casual sex and approximately 10 percent of them do not use condoms. The researchers concluded that there is a slow but steady transmission of HIV/AIDS in the district and women's lower socio-economic status and limited knowledge of HIV/AIDS increases their vulnerability.²⁶⁷ ARC was in the process of conducting an HIV/AIDS assessment among the armed services and commercial sex workers to plan HIV/AIDS programming.

Safe Motherhood, Family Planning, Gender-based Violence, Adolescents

No information was obtained.

²⁶⁵ Asian Research Center for Migration, Cross-border Migration and HIV Vulnerability in the Thai-Myanmar Border Sangkhlaburi and Ranong, March 2000.

²⁶⁶ Ibid.

²⁶⁷ Ibid.

Camps

Ban Don Yang

The assessment team visited Ban Don Yang refugee camp, which houses approximately 3,700 Karen refugees and is about a six- or seven-hour drive northwest of Bangkok in the Sangkhlaburi district of Kanchanaburi province. The camp is quite close to the border.

ARC is the main provider of clinical and health education services. ZOA offers educational activities, COERR is the social services provider and Shanti Volunteer Association is establishing a library in the camp. ARC has two RH supervisors and eight midwives and is the main implementing health partner in the camp, which has one health center and two referral hospitals. The Kwai River Christian Hospital (KRCH) is about a 45-60 minute drive from camp, and the more advanced Sangkhlaburi district hospital is in town and an additional 20 minute drive beyond the Kwai River Christian Hospital. ARC RH staff include 9 midwives, 4 TBAs and 15 CHEs, 7 of whom are male. ARC also employs a Clinical Coordinator that the RCH Coordinator and midwives consult for medical, including obstetric, complications as necessary. At the time of the assessment visit, ARC was planning to hire two new staff, one to work on training and capacity building and another to address mental health issues. Most staff speak Karen and Burmese and a few speak English and serve as translators for the RCH coordinator. MSF works across the border in three sites: Halochanee, Bee Ree and Tavoy. MSF also has a small satellite clinic with limited services at Tee Wah Doh, which is approximately 2½ to 3 hours from Sangkhlaburi. There are medics, some female, providing RH services.

Vaccines are kept in a gas-powered refrigerator. Kerosene lamps are used in the evening. A generator is available for showing educational videos.

The assessment team asked the RCH supervisors about the challenges they face in their work. They noted that emergency transport at night used to be a problem but now an ARC vehicle is available 24 hours a day, seven days a week. The other problem they highlighted was the distribution of a sarong to women who deliver. They said that refugee women have suggested that family planning users should also be given a sarong, which would create more equality among all women who lack funds to purchase new sarongs. In regard to successes, the RCH supervisors cited that immunization rates have increased and that all new babies are immunized.

Safe Motherhood

Antenatal, delivery and comprehensive EmOC, as well as essential newborn and postpartum care, are available.²⁶⁸ Most women deliver at the ARC clinic, which is about a 15-minute walk for the women living furthest from the clinic site. The four TBAs in this camp do not attend home births; however, they do receive training from ARC and provide support to pregnant women and new mothers in the clinic. There are an average of 10 deliveries per month with one to two women being referred each month for obstetric complications such as abnormal presentation and high blood pressure. Also, young women (ages 14 to 16) and women who have had a cesarean section before would also be referred. Women with high blood pressure are referred to the medics. Women are tested for anemia, malaria and syphilis. They receive education during their ANC visits on nutrition, future family planning and signs of high-risk pregnancy. They are encouraged to return with any questions or problems. Women also receive multivitamin supplementation, eggs and groundnuts. Neither vitamin A nor iodine deficiency is a problem in the community. RCH workers have been using the partograph since 2001 and initial difficulties in understanding and application have been overcome.

A recent BBC survey in the camp noted that women breastfeed their infants for an average of four months and the RCH coordinator was working with the staff to increase women's awareness of the benefits of breastfeeding their children for at least the recommended six months.

268 Inter-agency Working Group on Reproductive Health in Refugee Situations, Inter-agency Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons, Coverage Survey, Ban Don Yang camp, October 2003.

Family Planning

The Inter-agency Working Group global survey notes that condoms, pills and injectable hormones are available but IUDs are not offered as a contraceptive option. Depo-Provera is the most popular form of contraception, followed by pills and condoms, which are available in the RCH clinic 24 hours per day. If women stop using their method, staff follow up to find out why and complete a form describing the result of the visit. Often the reasons given are that the husband is away or that the couple is ready to have a baby or that the woman is experiencing side effects such as bleeding and dizziness. Those with side effects are counseled and testing is carried out at the clinic on anemia and blood pressure. In general, follow-up is good except for women who are living across the Burma border and come to the clinic on an irregular basis. A couple must agree upon any sterilization procedures. When a husband does not agree with his wife's request, CHEs are able to follow up with him at home for further discussion. Very few unmarried women come to the clinic for services and it is the same for adolescents who, staff say, are too shy to come for services. ARC Thailand policy states that EC is only available to rape survivors.

STI/HIV/AIDS

HIV-positive persons are treated for prevention and treatment of opportunistic infections; however, camp residents do not have access to VCT or anti-retroviral therapy.²⁶⁹ According to the Inter-agency global survey, pregnant women also do not have access to anti-retroviral therapy but are counseled on infant feeding choice.

The isolation of Ban Don Yang camp may be beneficial in that the KRC does not monitor RH activities too closely. For example, ARC refugee staff suggested to the RCH coordinator that condoms be made free and available in the camp clinic without requesting that the person write down his name. Currently, condoms are available through the CHEs and a box of condoms is available in the RH clinic 24 hours a day.

A consultant for ARC is conducting a feasibility analysis for VCT covering Ban Don Yang and the Umphang area. According to ARC, AMI does not want to be involved in pre- and post-test counseling and would limit its activities to performing laboratory testing.

Laboratory tests for STIs include syphilis, gonorrhea, candidas, trichomaniasis, bacterial infection and hepatitis B.

RCH supervisors noted one HIV case in 2000 in which the father and child died while the mother, who was HIV-positive, survived. The mother allowed a Karen couple to adopt her other daughter who was HIV-negative. Apparently, the woman remarried a Thai man who knows his wife's status and uses condoms and she still comes in for antibiotics and also uses traditional medicines.

Gender-based Violence

A GBV prevention program is in place and rape survivors do have access to EC, and although the health staff provide some support to survivors, specific psychosocial support is not offered.²⁷⁰

A protection working group for the area including Tham Hin and Ban Don Yang camps was meeting in Kanchanaburi on a bi-monthly basis. The group is not being covered under a more general coordination meeting that meets in Ratchaburi. The concern is that the already full coordination agenda in Ratchaburi would not be able to adequately address GBV issues.

The Women's Commission heard of two cases of alleged rape that occurred in 2002. One perpetrator, a local from a Thai village, was jailed and hung himself there. Another case was of a 60-year-old man who raped a 15-year-old girl. The RCH supervisors said the young girl said it was not a case of rape;

269 Inter-agency Working Group on Reproductive Health in Refugee Situations, Inter-agency Global Evaluation of Reproductive Health for Refugees and Internally Displaced Persons, Coverage Survey, Ban Don Yang camp, October 2003.

270 Ibid.

supposedly, the man supports the child that resulted from the pregnancy while the young woman lives with her parents.

ARC follows the BBG on care for rape survivors. Rape survivors would be referred to medics and offered EC and STI prevention. If the survivor wanted to press charges, she would be referred to the Sangkhlaburi district hospital for the necessary certification for legal prosecution. The other referral site, Kwai River Christian Hospital, cannot provide this certification. It is not clear whether the hospital offers post-exposure prophylaxis or VCT, but both are doubtful. ARC pays for referrals but limits referrals to life-threatening complications. There is no defined policy on the referral of rape survivors.

ARC has been requested to be the lead organization on GBV prevention and response activities on the border. ARC has been working with UNHCR to develop an overall action plan to address GBV issues. ARC wants to include community groups and work with UNCHR as well. Some refugees on the camp committee are supportive of these activities while others are not.

There have been some difficulties in working with UNHCR. The consent forms that UNHCR requests agencies to complete are said to be confidential but request the identity of the victim/survivor. In addition, there is a concern with consent of the victim/survivor. For example, the past ARC clinical coordinator completed a report about an attempted suicide. Apparently, the woman was abused by her husband. UNHCR confronted the couple without the consent of the woman. The confrontation led to the husband taking aggressive action against ARC staff when the ARC staff attempted routine follow-up on the woman's health status. ARC complains of lack of communication around the process, lack of mechanism for feedback or evaluation and a need for a constructive dialogue for improving the process.

Adolescents

ARC CHEs were providing 45 minutes of health education (hygiene, malaria prevention, etc.) in the schools for 10- to 16-plus year-olds. The RCH coordinator plans to meet with the school principal to discuss restarting the program now that school has started up again. There are no youth-friendly services or youth center for adolescents to have tailored access to RH information and/or services. After successful advocacy by the ARC RCH coordinator, pregnant adolescents are allowed to continue their schooling after regular school hours although the curriculum is limited, with fewer subjects available.²⁷¹ Lack of sanitary supplies also keeps young girls from attending school when they were menstruating.

The assessment team conducted separate focus group discussions with adolescent girls and boys. The participants were eight girls from the ages of 16 to 19 years, one of whom was married. The girls stated that the problems facing youth were early marriage and pregnancy and said the solution to this problem is education. The girls noted their lack of access to sanitary material during their menstruation, which causes some to stay home from school or hide behind friends to hide their embarrassment. Most youth do attend school, but once people marry, they do not continue to attend school. The one married focus group participant was not in school. There are more girls than boys in school. Reasons given included that boys are lazy or are working to support their family. Girls take part in activities like weaving, sewing and crocheting. The camp youth group organizes sporting activities. Adolescents learn about health from the CHEs, who come to the school to discuss topics such as malaria, diarrhea, STI/HIV/AIDS, TB, nutrition, anatomy, alcohol abuse, worms and dental care.

Girls have been to the RCH clinic but only for immunizations. Some said adolescents do not need RH services while others said their peers are too shy to go to the clinic. It is against the culture for unmarried people to use family planning. The girls agreed that unmarried adolescents are having sex and that it is important for young people to have access to condoms. Sometimes boys go outside of the camp to purchase condoms. They know condoms are available from the CHEs but again are too shy to ask for them. In the Karen culture, parents will make a young couple marry if they find out the youth are engaging in sex. Some said this is good while others said it is bad and leads to early pregnancy. One girl stated, "Here married people or pregnant girls cannot go to school."

271 ARC RCH/CHE Coordinator, Kristen Graham, Ban Don Yang Camp.

The girls recognized the importance of using condoms to prevent pregnancy and STIs and noted pills and Depo-Provera as other ways to prevent pregnancy. The focus group participants agreed that if a girl does not want to be pregnant, she must still deliver the baby. Others said there is some Burmese medicine, a powder, that one can get from the market to induce abortion. The girls know how HIV is transmitted and that you cannot tell by looking at people if they are infected. They expressed their concern about getting HIV. If they did have an STI, they would go to the hospital to be checked.

Another focus group was conducted with eight boys from the ages of 16 to 24 years, with three married participants. The boys stated that the main problem facing youth is violence, which the respondents defined as domestic violence. Health concerns cited by the boys included fear of contracting HIV. Four of the eight participants attend school. None of the married participants go to school. Reasons why boys do not attend school include that some are lazy, some disobey their parents, some are working to take care of their families, others are married and some are too old. The types of work youth can do include cutting, collecting, carrying and selling bamboo, mostly to Thai people, and also making brooms to sell in camp or to Thais in the local village. More girls attend school than boys because there are more girls in the camp than boys. One young man explained that more boys attended school in Burma because school was expensive; therefore, families would only send their boys who would be able to earn more money than girls in the future. Here in the camp, boys need to work to earn money for the family, while girls can perform their household chores while still attending school.

The typical marriage age is 15 to 16 for girls and 18 for boys. They learned about sex from the CHEs who came to the school to teach about RH anatomy. Some people wait to have sex until they are married and others have sex before marriage. One participant said that condoms make people more promiscuous because they could use condoms and have sex with many different people. Others agreed that young people who are having sex should have access to condoms. They were aware of one rape case in camp. They have heard about people who have sex for survival but have not seen these people. They do not know anyone who has paid to have sex or someone who has sex for pay.

Participants suggested that there are fewer incidents of violence now that they live in Thailand than there was in Burma due to more education on this topic. If a woman were beaten, she would go to the section leader who would talk with the husband about his behavior. Alcohol abuse is a problem in the camp but opium is not used. Alcohol abuse has been reduced due to a law passed by the camp committee prohibiting the sale of alcohol in the camp. Most of the focus group participants stated that this was a good idea. The boys noted that the ways to prevent HIV include using condoms, having one partner, not getting tattoos and not sharing needles. They are fearful of HIV and cancer. They also agreed that one cannot tell by looking at people if they have HIV.

Male Involvement

According to the Inter-agency global evaluation, men have access to information, education and communication activities but RH services do not specifically target them. Husbands do not typically accompany women on pre-natal visits. Sometimes they bring their children for growth monitoring visits or immunization. Men have expressed an interest in learning more about cancer, and ARC plans to use this as an entry point to involving men in more health-related activities.

Ratchaburi Province

Camps

Tham Hin Camp

The Women's Commission conducted a site visit to Tham Him camp, with a population of 9,000 refugees. MSF staff report that 50 percent of the population is under 15. Refugees are housed in an obviously overcrowded camp that is administratively divided into four zones with four to five sections per zone. MSF is the main health provider and currently has a gender-balanced local medic staff of eight, 12 nurses, including two men, and 18 home visitors (HVs), including 12 women and six men. A brief tour of the inpatient facility reveals a functioning inpatient ward and a well-equipped labor and delivery room, with the exception of MVA equipment. The Women's Commission's RH program director conducted two focus group meetings, one with 12 women from the KWO and the other with 18 HVs.

Safe Motherhood

KWO representatives reported that there has been very little change in marriage customs among the refugees. HVs report that adolescents marry at early ages, with most girls marrying at 15 while most boys marry at 17. The HVs believe this is because young people are living in very crowded conditions, lack jobs and other meaningful activity in the camp and that they are missing a normal culture. Generally, a couple decides to marry and a pastor marries them.

According to both KWO representatives and HVs, most women deliver at the MSF inpatient department, but occasionally TBAs assist with deliveries in the home. According to the HVs, TBAs in the camp are not trained but there was a recent midwife training. Referral to the local Thai Ratchaburi hospital is available for women suffering from complications of pregnancy. HVs report that sometimes women's relatives wait too long to notify health workers that the women are suffering from complications of pregnancy and delivery, with some waiting two to three days. In addition, a few problems were mentioned with the referral system; namely, husbands are not allowed to accompany their wives. Relatives who are allowed to accompany patients are not provided with food at the hospital and obtaining the necessary medications after discharge has been problematic in some instances. HVs did not recall any incidents of women who died from complications of pregnancy or delivery and recalled one infant death two to three weeks postpartum. Representatives of KWO recalled two women who died, two or three years ago, and did not report any infant deaths. According to respondents, most women breastfeed and have few problems.

Representatives of the KWO stated that there wasn't a problem in the community of women who are pregnant and do not want to be. HVs said that if this did exist, women would maintain/keep the pregnancy. If an unmarried woman or girl has a baby, HVs state that relatives will care for them. In addition, if they are pregnant, they are allowed to receive weekly food supplements after delivery up to nine months, a supplement the HVs believe is an incentive for pregnancy. Both KWO and HV representatives denied any issues surrounding unsafe abortion in this camp.

Family Planning

KWO representatives believe that most women were having fewer children in the camp because health education has improved since they left Burma. HVs echoed this, indicating that while family planning was not available in Burma, the availability of contraception in camp has changed people's desire for a large number of children. The KWO representatives themselves had zero to 11 children and with the exception of one woman who had one child and wanted one more, and another woman who had four children but wanted 12, 10 women did not want more children. Among HVs, 13 of 18 did not want more children, while five of them did. Some of them were using modern contraceptives, while one woman reported use of a dangerous traditional practice of externally manipulating the uterus with her hands to prevent pregnancy. KWO representatives explained that some midwives perform uterine manipulation for women to prevent pregnancy and if a couple wants children, the midwife is reportedly requested to turn the uterus back.

A broad array of modern contraceptive methods is available to refugees in the camp, including Norplant, Depo-Provera injections, oral pills, IUDs and sterilization, and the most popular methods are reportedly pills and injections. HVs are responsible for distributing condoms and will provide couples desiring to practice family planning a one-month supply. Of concern, neither the representatives of the KWO or the HVs had ever heard of EC, even for survivors of rape.

STI/HIV/AIDS

Focus group participants report that premarital sex occurs but deny that any homosexuality exists in the camp. KWO and HV representatives were able to state the major modes of HIV transmission and prevention and reported that while some people know this well, some do not. KWO representatives provide HIV/AIDS education for youth, separating the younger (12 to 15 years) adolescents from the older (16 to 25 years) youth in their training. According to KWO representatives, HVs are known to maintain a supply of condoms in their section of the camp and if people plan to go out of the camp they are provided with a one- to two-week supply of condoms. HVs have used some creative approaches to ensure condoms are available, such as putting them in a small box and hanging them high in a tree or in a latrine so that adolescent men are able to access them without asking. However, the KWO and HVs report that the condom supply has been depleted for one month! A box marked condoms hanging from a bamboo pole in the hospital was also empty, while several boxes of condoms were observed in the hospital supply room. When KWO participants were asked if they had ever seen or known anyone with HIV/AIDS, some participants smiled and giggled and responded that they had suspicions, but did not know if anyone has HIV/AIDS for sure. Both KWO and HV participants reported that VCT is available at the hospital.

Gender-based Violence

HVs reported that some young girls marry older Thai men and also said that Thais also show inappropriate video movies in the camps disrupting the Burmese culture. Both KWO and HV representatives said that domestic violence was a problem, often stemming from alcohol abuse by men. One incident reportedly occurred when a man arrived in the camp after having been outside the camp and his wife said that he had to use a condom. Some HVs believed that domestic violence was acceptable if a man's wife falls in love with someone else.

Focus group participants also said there were a few women who had sex as a means of survival and that rape happens, although it was very rare. If a rapist is caught, the HVs said that he would be punished by death. Rape cases are reported to the camp committee and the Thai authorities. The HVs said there had been no GBV training in the camp. Some components of care, such as EC and STI prevention, are available to rape survivors; however post-exposure prophylaxis for HIV/AIDS is not.

Adolescents

Secondary school is available for adolescents and the KWO report that in this setting more girls than boys attend. Both KWO and HV representatives reported that young men and women have sex before marriage and one or two young women become pregnant in every section of the camp each month, creating a community problem. Supplemental food for pregnant women was reiterated as a problem because they believe that when young women have problems with their parents or husbands, they know they will receive food and can manage on their own.

Ranong Province

Ranong Province is located on the southwest coast of Thailand adjacent to the southern Burmese town of Kawthaung. The population of Ranong is 170,000 and the number of migrants varies from 40,000 to

100,000 depending on the economy.²⁷² The overwhelming majority of migrants are from Burma, primarily of Burman, and also Mon, Tavoyan, and to a lesser extent, Karen, descent. Migrants make the three-kilometer journey across the Andaman Sea by ferry or small boats or walk through border crossings in Ranong and Kraburi districts, to seek employment in the seafaring and services industries, on rubber plantations and fruit orchards, and in sawmills, construction, manufacturing or sex work. Women represented approximately 38 percent of the official migrant workforce in 2000, while others worked unofficially in commercial sex work or traveled with their families and were not employed.²⁷³

Most migrants live in deplorable conditions in the port area with overcrowded housing and poor water and sanitation. The economic downturn had made the situation more desperate for people and their economic livelihood was a primary concern. Migrant employers are not interested in the welfare of migrants and the sanitation facilities are very poor. The Provincial Health Officer (PHO) reports that zoning for migrants to manage sewage and sanitation and training of migrants on hygiene is needed.²⁷⁴

In a study conducted by the Asian Research Center for Migration (ARCM) in 1999, researchers report that approximately 50 percent of the migrant population had lived in Ranong for more than three years and planned to return to Burma once they were able to save enough money. Burmese tend to live in Burmese communities and are not integrated with the local Thai population. In addition, children are not allowed to attend Thai schools and public health services are not well accessed. The researchers suggest that cultural differences and unfavorable attitudes by Thais, including the authorities, may contribute to migrants' plans to return home.²⁷⁵

The Ranong PHO reports that environment health—clean water and sanitation, RH, including maternal child health, and communicable diseases—are the priority health concerns of the migrant population. PHC services that include antenatal care, family planning, screening for drug use, syphilis, STIs, tuberculosis and HIV testing with group counseling, provided by the MOPH are available to migrants if they have insurance coverage. However, only 18,203 of approximately 60,000 migrants had insurance to cover health care costs. The MOPH reported that it was unable to reach the migrants because too few are insured and its overall budget is inadequate.²⁷⁶

Public health services in Ranong include one provincial hospital and four district hospitals. WV established a clinic at the port in Ranong from 1994 to 1996 that was quite popular initially and eventually became self-sufficient but was later closed for several years due to funding problems. With support from the MOPH the clinic was subsequently relocated to the other side of town from the port. The move of the clinic from the port was unfortunate because migrants, particularly fisherman, who could conveniently access care at the shore in the old clinic, now must pay for transport to the other side of town and also risk a security incident. WV has considered securing a van or bus that would travel regularly from the port to the clinic but it is also concerned about the security risks this could pose. Migrants primarily access the clinic for outpatient/preventive care such as vaccinations, antenatal care and contraceptives for those who request them. WV struggles to maintain the clinic but faces the problem of a continuous shortage of medicines because its funding is primarily targeted for specific programs, for example, HIV and trafficking. In addition, community-saving schemes have failed due to the movement of people across the Thai-Burma border and out to sea. WV works with more than 200 community volunteers; some are housewives and social network volunteers and others are sex workers. While some people still come to the clinic and WV volunteers refer people to its clinic, very few access services at the clinic. Most people who are sick go directly to the hospital and some migrants are referred by WV. If migrants were registered it cost them 30 baht for care at the hospital, and if not they had to pay for services.²⁷⁷

272 MOPH Meeting, Dr Thongchai, Ranong Province, March 31, 2003.

273 Asian Research Center for Migration, Cross-border Migration and HIV Vulnerability in the Thai-Myanmar Border Sangkhlaburi and Ranong, March 2000.

274 MOPH Meeting, Dr Thongchai, Ranong Province, March 31, 2003.

275 Asian Research Center for Migration, Cross-border Migration and HIV Vulnerability in the Thai-Myanmar Border Sangkhlaburi and Ranong, March 2000.

276 MOPH Meeting, Dr Thongchai, Ranong Province, March 31, 2003.

277 Meeting, Dr Naing, World Vision, March 28-29, 2003.

There is also a private clinic in Ranong that is open 24 hours per day, but it is expensive. Many people self-treat or seek advice from a pharmacist and pay for what medicines they can afford. Some people use “quack injectors” and spiritual healers.²⁷⁸

Safe Motherhood

Focus group participants in Ranong stated that it is a cultural norm to be supportive of pregnant women. However, if an unmarried woman becomes pregnant they said that she should get married or she will be ostracized. Participants also said that women who have money deliver in health facilities and those that do not seek the assistance of one of the approximately 15 TBAs in the community. The participants also report that TBAs induce abortions and that they were collectively aware of four women who died from the complications of an unsafe abortion.²⁷⁹ In a study conducted in 1998, nearly half of migrant women were reported to deliver their children at home with a TBA and the other half at a hospital or clinic either in Burma or Thailand. Some migrant women in Ranong chose to cross the border to Burma to avoid health care costs in Thailand and to access health care in their own language, while other women from Burma sought emergency care in Thailand. Other factors that influenced women’s decisions about where to deliver included ease of travel and the support of their employers, particularly in rural areas. Sixty-five percent of the study participants in Ranong reported serious or very serious health problems during and after delivery.²⁸⁰

Regardless of ability to pay or legal status, Ranong provincial hospital admits approximately three or four migrant women, and women who come from Burma, per day, for deliveries, as well as one or two Burmese women per day with obstetric care needs from complications of unsafe deliveries and unsafe abortion.²⁸¹ Sixty percent of women also received postnatal care at a hospital or clinic in Thailand or Burma.²⁸²

Family Planning

The MOPH reports that many women want family planning because they want to work and to delay having children, but there are no funds to support family planning.

Among 10 migrant sex workers that DOW met in Ranong, none of the group participants were using contraception at the time, and they readily acknowledged that it is common for women to go to a local migrant abortionist, despite the known dangers, through the late stages of the second trimester of pregnancy.²⁸³

Focus group participants reported that men tend to want many children to care for them in their old age. However, due to the high cost of living, especially since 1995, they said people plan to have fewer children. Participants were able to cite most modern methods of contraception.²⁸⁴

In the study conducted of migrants in 1998, more than 85 percent had ever heard of oral contraceptives, injectables, condoms and sterilization, yet only 24 percent had ever used pills that were primarily (58 percent) purchased through local vendors, 32 percent had ever used injectables, 13 percent had ever used condoms and six percent had ever used sterilization. While approximately half of migrants had

278 Focus Group with seven World Vision volunteers, April 1, 2003.

279 Ibid.

280 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

281 Doctors of the World, Field Mission to Thailand-Burma Border Concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001, July 2001.

282 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

283 Doctors of the World, Field Mission to Thailand-Burma Border Concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001, July 2001.

284 Focus Group with seven World Vision volunteers, April 1, 2003.

heard of Norplant and IUDs, ever-use of Norplant was uncommon (nine percent) and of IUDs was rare (one percent). Researchers also learned that the overwhelming majority of participants did not have correct knowledge about a woman's menstrual cycle and patterns of fertility while 22 percent of participants had ever used withdrawal for birth control. Finally, approximately one-third or more of participants were interested in learning more about contraceptive methods, particularly injectables.²⁸⁵

WV conducts outreach to promote family planning and brings TBAs to its clinic for workshops and training about the dangers of unsafe abortion. Now that the economy has declined and business is down, owners of sex workers are more interested in protecting their investment in girls and women and are more open to allowing WV to provide family planning. However, this support by owners is offset by the fact that once the girls recognize the risks they face (through education from WV) they often want to leave sex work, upsetting owners. The girls are then fearful of what the owners will do. In addition, some brothel owners have been known to force contraception. And in some situations according to WV, the girls and women do not use contraception and suffer from unwanted pregnancies. TBAs perform unsafe abortions up to as late as seven months, according to the WV representatives. WV purchases and provides contraceptive supplies, usually Depo-Provera, to sex work network representatives and TBAs, who sell them to women.

STI/HIV/AIDS

The MOPH reports the prevalence of syphilis among registered migrants was 4.03 percent in Ranong in 2002.²⁸⁶ The Mahidol University study showed that 33 percent of migrants responding to its survey had experienced a discharge, with 53 percent indicating it was at least somewhat serious. Significantly, 47 percent did not seek any treatment for the discharge, while an additional 31 percent sought care from a traditional healer. In addition, 46 percent of respondents experienced burning with urination and over one-third of them did not seek care, 23 percent visited a traditional healer and 25 percent sought care at a health facility.²⁸⁷

The MOPH in Ranong reported that 2002 HIV/AIDS surveillance data from Ranong indicates an HIV prevalence of 1.7 percent among pregnant women, 36.2 percent among female commercial sex workers from Burma, 1.1 percent among male commercial sex workers from Burma, and 10 percent among fisherman.

In a meeting with a small group of migrant seafarers, DOW heard that the seafarers had never heard of HIV/AIDS before they arrived in Thailand, but that they had seen people dying from AIDS and were therefore somewhat more likely to take precautions by using a condom with a commercial sex worker as a result. DOW reports that while work at sea brings its own risks to fisherman, such as sharing needles for ear piercing, the lack of work and idleness at port for months on end also lead to risk taking, such as substance abuse and unsafe sex with commercial sex workers.²⁸⁸

In its research conducted in 1999, ACRM researchers found that migrant women had low levels of knowledge about HIV/AIDS. They also report that Ranong has a well-established sex industry despite the Thai government's closure of brothels in the early 1990s. In addition, the study findings show that migrants participate in a variety of sexual relationships, including regular partners, casual partners and commercial sex workers. According to this study, approximately 500, mostly Burmese, indirect sex workers engage with Burmese, Thai and foreign clientele in the entertainment venues where they work. In addition, condom use was reported to be low, primarily due to the costs of condoms and lack of availability. ACRM researchers conclude that there is both rapid and slow transmission of HIV in Ranong, with rapid transmission occurring among commercial sex workers, their clientele and injecting drug users,

285 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

286 Dr Tares Krassanairawiwong, The Meeting on Development of Health Collaboration Ranong Province, Conference Notes, March 27- 28, 2003.

287 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

288 Doctors of the World, Field Mission to Thailand-Burma Border concerning the Health and Human Rights of Migrants from Burma/Myanmar: March 19 to April 2, 2001, July 2001.

and a slower HIV transmission occurring in the population through unsafe sex among casual and regular partners. Finally, health services were reported to be difficult to access, and only pursued as a last option due to migrants' illegal status, costs and language barriers. These constraints are compounded by a lack of funding at the district hospital to support HIV prevention and care services.²⁸⁹

WV Thailand established a program in Ranong in 1992 that for several years focused on prevention of HIV/AIDS among commercial sex workers and fishermen. In mid-1994 the Thai Ministry of Health undertook a major initiative to close brothels in Thailand. After two years WV reports that they began to see the emergence of commercial sex workers originating or occurring outside of brothels in restaurants, clothing stores and karaoke bars. Although WV continued its work with fishermen throughout the 1990s, funding constraints prevented its continued work with commercial sex workers again until 2002. WV works closely with the PHO, from which it receives condom supplies. In addition, STI/HIV/AIDS patients are referred to the MOPH weekly STI clinic where VCT is implemented for syphilis and HIV/AIDS.²⁹⁰ One focus group participant explained, "Mostly people don't want to know they have HIV/AIDS."²⁹¹

Although several migrants with end-stage AIDS visit the WV clinic per week, there are essentially no social services for persons living with HIV/AIDS in Ranong. However, WV collaborates with its partner agency in Burma to facilitate the return of PLWHA to their home communities.²⁹² WV conducts workshops on family planning, HIV, life skills and negotiation skills. Sex workers are approximately 14 to 35 years old. Most girls and women were not sex workers in their own country and they became separated from families. They are usually not registered. Girls and women undertake sex work discreetly while employed in a restaurant or as a vendor in a clothing shop. WV also works with MSM by providing social support, assistance and specific messages that could facilitate changes in behavioral norms such as alcohol abuse and unsafe sex.²⁹³

WV's program also includes social network and peer education programs to support fishermen who often have no money and limited social supports. For example, if the fishing catch is bad, and the economy has been in serious decline in recent years, fishermen cannot afford a place to stay when they return to shore in Thailand. Lack of money and few social supports tend to foster low self-esteem, alcohol abuse and subsequent unsafe sex. The social network members are identified women or men, primarily older women, who have space in apartments or homes available and provide rooms and meals for these men at reduced rates, and, in exchange, the proprietor has a regular customer whom they come to know and support with information and advice about living in Thailand. In some cases the social network members help the men to set life goals as many lack social opportunities and self-esteem. These regular customers are also allowed to stay and receive meals and pay when they can. Social networkers also provide training to peer educators to function as community health volunteers among the target groups of seafarers, sex workers and the general community. Community volunteers are compensated with free health care at Thai clinics. Social networkers also accompany patients to the hospital and clinics to provide translation and support.²⁹⁴

Gender-based Violence

The "major crackdown" on brothels in 1994 led to more trafficking of women and lowered health workers' access to commercial sex workers. According to the findings of DOW, there are hundreds of girls and women known to be working in the back rooms of karaoke bars in Ranong who are considered "indirect" commercial sex workers. The women, in debt-bondage to the bar owners, often report that they came to Thailand looking for work in the service industry and were unknowingly trafficked into sex work with a contract that they were indebted to. WV also reports a trade in virgin girls and is aware of five current

289 Asian Research Center for Migration, Cross-border Migration and HIV Vulnerability in the Thai-Myanmar Border Sangkhlaburi and Ranong, March 2000.

290 Meeting Dr Naing World Vision, March 28-29, 2003.

291 Focus Group with seven World Vision volunteers, April 1, 2003

292 Caouette, T., Kritaya Archanvanitkul, et al. *Sexuality, Reproductive Health and Violence: Experiences of Migrants from Burma in Thailand*, (Institute for Population and Social Research, Mahidol University, 2000).

293 Meeting, Dr Naing, World Vision, March 28-29, 2003.

294 Ibid.

cases. The girls are traded through both Thai and Burmese middleman and the value is from 5,000 to 10,000 baht (US\$125 to US\$250). WV also works to prevent sex-work trafficking. They network with police, immigration and the social welfare department and conduct cross-border work to facilitate communication.²⁹⁵

According to focus group participants, domestic violence is a problem particularly around alcohol abuse.²⁹⁶ WV has also conducted numerous trainings with police about the problems of migrants, including domestic violence.²⁹⁷ In addition, focus group participants stated that if a woman has been beaten or raped by a Thai man, a woman would not say anything to anyone for fear of getting killed. Village leaders offer some protection to women without partners.²⁹⁸

Adolescents

Focus group participants report many problems among youth, including early marriage, with children born soon after marriage, and subsequent divorce. Marriage customs have changed among Burmese in Thailand because young people used to marry at 18, and many now marry as young as 13 or 14. Participants explain that this is due to a lack of guardianship because parents work in Thailand and cannot look after their children properly. There are also more inter-ethnic marriages between Burmese and Thais because Burmese girls are working in homes as maids and available as shop and service girls. Youth also abuse alcohol and drugs and focus group participants estimate that approximately 20 percent of young people have sex outside of marriage.²⁹⁹

There are three informal Burmese schools, but the schools are very crowded and there is only one teacher for all three schools. Jesuit Relief Services provides support for two schools in Ranong. WV has provided RH education in the three secondary level schools and also holds an adolescent workshop on RH for approximately 20 adolescents once every three months. The migrant community in Ranong has organized some limited activities with migrant adolescents, including health training. The community collects small user fees to pay for the space, water and electricity for training programs.³⁰⁰

UNFPA has slowly expanded collaboration with WV, as the MOPH has agreed to allow it to support the RH of migrant populations to address STI/HIV/AIDS, family planning, safe motherhood and adolescent RH in Ranong. UNFPA is supporting an RH KAP assessment and workshops and training on family planning and community-based distribution of supplies, as well as HIV/AIDS prevention activities. With funding support from UNFPA, WV is currently planning to implement a four-year mobile clinic to reach migrants in collaboration with the PHO in Ranong from 2003 to 2006. The mobile clinic will be staffed with MOPH doctors and nurses as well as Burmese physicians and volunteers.

Additional Findings

An assessment team member heard about an incident where attempts were made by a father to sell his infant, reflecting the severe economic hardship of migrants. In this case a man in Ranong could not pay off a debt to his employer, who had beaten and threatened him. At the same time, his wife was suffering at home from mental health problems three months after the birth of their child. WV intervened to pay off the debt and contacted the police. The police arranged for immediate deportation of the family for its own protection.³⁰¹

295 Women's Commission for Refugee Women and Children, Meeting notes with World Vision Bangkok, January 2003.

296 Focus Group with seven World Vision volunteers, April 1, 2003.

297 Meetings with Dr Naing, World Vision, March 28-29, 2003.

298 Ibid.

299 Focus Group with seven World Vision volunteers, April 1, 2003.

300 Meetings with Dr Naing, World Vision, March 28-29, 2003.

301 Meetings with Dr Naing, World Vision, March 28-29, 2003.

Conclusions

There is a vast difference between the lives of migrants and other people living in refugee-like circumstances and refugees who are based in the nine camps along the Thai-Burma border. While those who are living in camps are provided basic security, access to shelter, sanitation, food, water and health care, migrants and those living in refugee-like circumstances face a daily struggle for their survival needs which significantly impacts their RH. The situation for IDPs in Burma, not surprisingly, is the most dire for the population in terms of needs and the dearth of services available to them.

IDPs in Burma

Although the assessment team did not travel to Burma, the BPHWT studies and reports indicate that they are achieving greater access to the IDP population with an increasing focus on RH. Pregnant women in the accessible areas have access to some components of antenatal care, such as care for malaria, iron and folate prophylaxis and clean delivery supplies. Despite the valiant efforts of the BPHWTs working in this highly unstable area, there are major and critical gaps in RH programming for even the populations that are reached. For example, tetanus toxoid immunization and syphilis testing are not available to pregnant women. In addition, according to the BPHWT survey, there is a high percentage of induced abortions among IDP women, reflecting the unmet need for contraception, and there is a lack of trained health workers and supplies for EmOC. Moreover, condoms are only available to married couples for birth spacing. Early marriage and adolescent pregnancy are also common. Finally, there is a serious lack of adequate supplies and financial resources to meet the needs of the IDP population.

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

Since 2000, significant efforts have been made and progress achieved, most notably by local NGOs, in reaching the hundreds of thousands of migrants and people living in refugee-like circumstances on the Thai-Burma border with PHC, including RH. In addition, international, national and local organizations working on the border have instituted regular coordination meetings since 2000 to address the health needs of this population. However, PHC, including RH care, is not systematically available to migrants and others living in refugee-like circumstances, resulting in poor health outcomes for these women, adolescents and men. Often as a consequence of the lack of PHC, the MOPH, international organizations and their donors have absorbed the burden of the costs for tertiary care at referral hospitals.

Migrants and others living in refugee-like circumstances often lack knowledge about basic reproductive anatomy and physiology to protect their health and well-being. Many migrant women lack access to mosquito nets and routine ANC and suffer complications of malaria in pregnancy. Some pregnant women are subjected to the dangerous practices of untrained TBAs and do not know about, or are unable to access, life-saving EmOC. Family planning is not widely known or practiced, resulting in a significant number of women having unsafe abortions and suffering subsequent life-threatening complications. In breach of international law, migrants do not have access to birth registration, resulting in newborns being statelessness and increasing their vulnerability to trafficking. Migrants also have limited access to prevention and treatment of STIs, including HIV/AIDS. Finally, migrant women and girls face untold levels of GBV in detention centers, places of employment and in their daily lives without access to medical care, social and mental health services or justice.

Refugees in Camps

Access to and quality of RH services have vastly improved over the past decade for refugees based in the camps along the Thai-Burma border. Some RH services vary significantly in different camp settings and have for years, even within the same agencies. Some agencies have provided comprehensive services within some components of RH for decades; for example, MSF and SMRU have provided comprehensive safe motherhood services for the past 18 years in Mae La and other camps and have also taken a global lead on HIV/AIDS programming in some but not all of the camps. Clearly, challenges

remain in achieving comprehensive RH services in all components of RH as outlined in the *Inter-agency Field Manual on Reproductive Health for Refugees* in all camps.

In general, safe motherhood services are good, with high antenatal coverage, most deliveries attended by a TBA or midwife with variable training and access to EmOC in most sites 24 hours a day, seven days a week, resulting in low maternal and neonatal death rates. Although a range of family planning options is available, cultural constraints and lack of awareness among the population keep user rates low. The newer technical areas of STI/HIV/AIDS and GBV are the least developed in most of the Thai border camps. Awareness and understanding of HIV has increased among the communities; however, gaps in information remain. In addition, there is also a great deal of stigma attached to those who are living with HIV. On the other hand, Mae La camp is one of the only, if not the only, refugee site in the world where refugees have access to comprehensive PMTCT and anti-retroviral therapy.

Domestic violence is the most common form of GBV in the camps. There is a varied response from local and international NGOs on providing the necessary clinical and emotional care for rape survivors. In addition, forms of legal recourse vary and there is not a standard manner in which a survivor is informed of her choice as to whether to pursue justice through the Thai legal system. In some cases, communities take it upon themselves to resolve cases of rape, which can be harmful to the survivor.

There is a dearth of youth-friendly services and the religion and culture of the community keep young people from accessing services and supplies to protect their health. Generally, men have not been involved in a meaningful way in promoting their health or the RH of their partners and families.

Comprehensive Recommendations

Comprehensive recommendations include key recommendations for all population subgroups, including IDPs, migrants and camp-based refugees, and recommendations for each population subgroup.

General

International, national and local organizations should work together to support comprehensive education for ethnic community leaders about RH and gain their support for condom availability, for all men, women and youth, not just married couples, to prevent the transmission of STI/HIV/AIDS and to address other controversial RH issues, such as adolescent RH and EC.

All organizations including: community groups and leaders, local and international NGOs, MOPH and UN agencies should increase coordination and collaboration at all levels to support the provision of RH services to migrants, refugees and IDPs in Burma.

One organization should establish an RH task force representing community groups, other local, national and international organizations to collaboratively establish standard RH protocols and training curriculum; conduct training workshops on RH education and services including clinical care, adolescent RH and program monitoring and evaluation.

All organizations should seek to increase funding for RH services.

Safe Motherhood

All agencies working in the health sector should ensure that there is a clear system for referral of emergency obstetric patients with the capacity for health workers to provide basic EmOC to stabilize patients prior to transporting them to a referral hospital. The referral hospital should have an adequate number of competent staff and sufficient materials and supplies to provide comprehensive EmOC (basic EmOC plus blood transfusions and cesarean sections) 24 hours per day, seven days per week. A new

resource, *Field-friendly Guide to Integrate EmOC into Humanitarian Programs* is available in English at www.rhrc.org.

Family Planning

All agencies working in the health sector should increase awareness of family planning methods and do appropriate follow-up with all users and defaulters to ensure women and men are satisfied with their choice of method and have not stopped using contraception due to side effects, misunderstanding of use or other reasons that could be addressed.

Local and international organizations should inform women of the availability of EC for rape survivors, as well as a back-up method when the regular contraceptive method fails or a contraceptive method is not used. A new resource, *Emergency Contraception for Conflict-Affected Settings: An RHRC Consortium Distance Learning Module* is available in English and Burmese at www.rhrc.org.

STI/HIV/AIDS

All agencies working in the health sector should ensure that their staff are adhering to standard guidelines for the prevention and treatment of STIs. A new resource available is *Guidelines for the Care of Sexually Transmitted Infections in Conflict-Affected Settings*, developed by the Women's Commission on behalf of the RHRC Consortium and available at www.rhrc.org.

All agencies working in the health sector should provide care and support to PLWHA.

All agencies working in the health sector should continue to train their staff on HIV prevention and treatment guidelines. Two new and important resources are: 1) IRC's *Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations* and 2) *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers* developed by the Women's Commission on behalf of the RHRC Consortium available at www.rhrc.org.

Gender-based Violence

All health workers should provide clinical care for women who have survived rape, including EC and post-exposure prophylaxis for HIV/AIDS. Please refer to *Guidelines on the Clinical Management of Rape Survivors* (WHO/UNHCR 2002) available at www.rhrc.org.

UNHCR, donors and international organizations should increase funding and technical support to local NGOs to increase their capacity to provide medical, psychosocial and legal care for survivors of GBV and to support education about human rights. Additional support is needed for safe houses, job skills training, education and income generation opportunities for women and girls who have survived GBV, including rape, sexual exploitation, commercial sex work and trafficking. Recent GBV technical resources include: *Guidelines for Prevention and Response: Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons* (UNHCR, 2003); *GBV Tools Manual for Program Assessment, Design, Monitoring and Evaluation and Communication Skills in Working with Survivors of Gender-based Violence: A Five-Day Training Curriculum* produced by the Women's Commission on behalf of the RHRC Consortium and available on the RHRC Consortium web site at www.rhrc.org.

Adolescents

All agencies should ensure adolescents are involved in the assessment, design, implementation and evaluation of services and activities for young people.

All agencies should work with community members to improve RH services for adolescents that are acceptable to the community.

All agencies should advocate for pregnant and married adolescents to continue their education in school.

All agencies should ensure girls have access to sanitary supplies.

All agencies should either implement or support youth organizations to provide programs such as peer education, life skills development and vocational training.

Male Involvement

All agencies should work to involve men in health education and outreach efforts to gain their support for emergency referral and transport of women suffering complications of pregnancy and childbirth, birth spacing for healthier families and STI/HIV/AIDS and GBV prevention and response.

IDPs

General

BPHWTs should focus their interventions on the MISP in the most unstable IDP areas. The MISP is a set of priority activities designed for implementation in the initial stages of an emergency that aim to reduce maternal morbidity and mortality, prevent and manage the consequences of sexual violence and reduce the transmission of HIV. This could be followed by more comprehensive RH services in the most stable IDP areas. A fact sheet on the MISP is available at: www.rhrc.org

Safe Motherhood

Donors and NGOs should support the BPHWTs to increase the number of stationary referral centers in the most stable IDP areas for more comprehensive safe motherhood programming, including safe blood transfusion, oxytocic drugs, MVA and support for emergency transport of women requiring cesarean sections.

Family Planning

BPHWTs, trained TBAs and volunteers should provide community-based distribution of contraceptives, including condoms, birth control pills and EC.

STI/HIV/AIDS

All BPHWT members, local NGOs and others working in IDP areas should make free condoms visible and available to men, women and youth in Burma.

Adolescents

BPHWTs, local NGOs and others working in IDP areas should widely disseminate basic information, education and communication materials on RH, particularly the dangers of early marriage and pregnancy, contraception and prevention of HIV/AIDS, translated in all local languages with pictorials, to adolescents in the IDP areas.

Non-camp Refugees, Burmese Living in Refugee-like Circumstances and Migrants

General

The Thai government should recognize Shan refugees in the north and provide them protection and humanitarian assistance.

The Thai government, local, national and international organization representatives should increase migrants' and others living in refugee-like circumstances access to PHC, including RH, by addressing known barriers to care, such as: increasing opportunities for migrants and their families to registration by

decreasing registration costs and better informing them of benefits such as health insurance; hiring more Burmese staff and interpreters at clinics, hospitals and for community outreach; increasing mobile clinics with RH services staffed with Burmese professionals and paraprofessionals; and disseminating information in local languages about where and how to access health services.

The MOPH and all other workers in the health sector should strive to continuously improve data collection, analysis, documentation and dissemination of migrant RH.

Safe Motherhood

MOPH, local, national and international NGOs representatives should facilitate community creation and financing of emergency transportation schemes for women with emergency obstetric complications and consider supporting communities with mobile telephone or radio access to promote immediate transport of women to referral facilities as needed.

Family Planning

MOPH, local, national and international NGO representatives should increase community and employment-based education and distribution of contraceptives through trained community health volunteers, including peer-educators.

STI/HIV/AIDS

MOPH, local, national and international NGO representatives and donors should establish care and support programs, such as home care and hospice care, for migrants living with end-stage AIDS.

Gender-based Violence

The Thai government should work with immigration, police, health, legal and social services to address the protection needs of migrants, while holding the perpetrators of GBV accountable for the widespread violations of migrant women and girls.

Refugees

General

Local and international NGOs should consider providing sarongs (perhaps as an income generation activity) and other incentives to all women of reproductive age in the camp rather than only to pregnant women in order to ensure that sarongs or other items such as soap are not seen as incentives to promoting childbirth.

Safe Motherhood

All agencies working in the health sector should undertake ongoing (annual) training of their medic and midwifery staff in basic EmOC, including use of the partograph and MVA, to ensure appropriate care for the treatment of miscarriage and complications of unsafe abortion.

Family Planning

All agencies working in the health sector should ensure that women choosing sterilization are aware that it is a permanent contraceptive method and that they have given full consent to the procedure.

STI/HIV/AIDS

All agencies should continue to increase HIV knowledge in refugee communities to prevent HIV transmission as well as to reduce stigma toward people living with HIV.

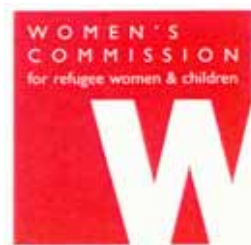
All agencies providing health services should implement HIV/AIDS VCT and PMTCT services and work to secure funding for anti-retroviral therapy.

All agencies working in the health sector should provide treatment of opportunistic infection, nutrition supplementation and other care and support to people living with HIV.

Gender-based Violence

Local and international NGOs, UNHCR and Thai authorities should continue to strive for a coordinated multi-sectoral response to GBV.

All medics should receive ongoing training in the clinical management of rape survivors following the established guidelines.



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